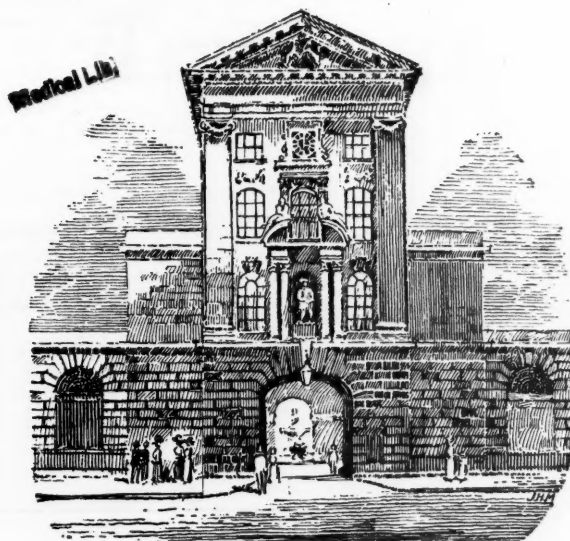


MAY 25 1932

ST BARTHOLOMEW'S HOSPITAL JOURNAL



VOL. XXXIX.—No. 8.

MAY, 1932.

[PRICE NINEPENCE.

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"Æquam memento rebus in arduis
Servare mentem."
—Horace, Book ii, Ode iii.

JOURNAL.

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CALENDAR.

- Mon., May 2.—Special Subjects: Clinical Lecture by Mr. Just.
Tues., „ 3.—Sir Thomas Horder and Sir Charles Gordon-Watson on duty.
Wed., „ 4.—Surgery: Clinical Lecture by Mr. Harold Wilson. Cricket Match v. Wanderers. Home. Tennis Match v. St. Thomas's Hospital. Away.
Fri., „ 6.—Medicine: Clinical Lecture by Sir Thomas Horder. Dr. C. M. Hinds Howell and Mr. Harold Wilson on duty. Swimming Match v. Old Millhillians. Away.
Sat., „ 7.—Cricket Match v. Hampstead. Home. Tennis Match v. London Hospital. Home.
Mon., „ 9.—Special Subjects: Clinical Lecture by Dr. Cumberbatch.
Tues., „ 10.—Dr. Gow and Mr. Girling Ball on duty.
Wed., „ 11.—**View Day.**
Thurs., „ 12.—Swimming Match v. University College. Home.
Fri., „ 13.—Medicine: Clinical Lecture by Dr. C. M. Hinds Howell. Prof. Fraser and Prof. Gask on duty.
Sat., „ 14.—Cricket Match v. Winchmore Hill. Home. Tennis Match v. Balliol College, Oxon. Away.
Sun., „ 15.—Whit-Sunday.
Mon., „ 16.—**Bank Holiday.** Cricket Match v. Croydon. Home.
Tues., „ 17.—Sir Percival Hartley and Mr. L. Bathe Rawling on duty.
Wed., „ 18.—Surgery: Clinical Lecture by Mr. Girling Ball. Swimming Match v. Old Citizens. Away.
Thurs., „ 19.—**Last day for receiving matter for the June issue of the Journal.**
Fri., „ 20.—Medicine: Clinical Lecture by Sir Percival Hartley. Sir Thomas Horder and Sir Charles Gordon-Watson on duty.
Sat., „ 21.—Cricket Match v. Metropolitan Police. Away. Tennis Match v. R.N.C. Greenwich. Home.
Mon., „ 23.—Special Subjects: Clinical Lecture by Mr. Elmslie.
Tues., „ 24.—Dr. C. M. Hinds Howell and Mr. Harold Wilson on duty.
Wed., „ 25.—Surgery: Clinical Lecture by Sir C. Gordon-Watson. Swimming Match v. Old Paulines. Away. Athletic Club: **Annual Sports** at Winchmore Hill.
Thurs., „ 26.—Cricket Match v. M.C.C. Home.
Fri., „ 27.—Medicine: Clinical Lecture by Sir Thomas Horder. Dr. Gow and Mr. Girling Ball on duty. Cricket Match v. St. John's College, Cambridge. Away. (2-day match.)
Mon., „ 30.—Special Subjects: Clinical Lecture by Mr. Scott.
Tues., „ 31.—Prof. Fraser and Prof. Gask on duty.

EDITORIAL.

THE outstanding Hospital event of the past month was the visit of Prof. Hugh Cabot from the Mayo Clinic. This visit, unlike his last, was an unofficial one, and we regret that we did not see more of him. Prof. Cabot is a lecturer of wide fame, and those who heard him on "The Present Position of Prostatic Surgery" were not disappointed. This lecture is specially interesting when compared with his address on a similar subject in June, 1926; we hope to publish it in full in our next issue. We greatly enjoyed his films of travel and wild life in British Columbia and his delightful running commentary. Prof. Cabot possesses that American quality of humorous phrase-making which gave added zest to travel film and surgical lecture alike.

* * *

THE JACKSONIAN PRIZE.

The Jacksonian Prize of the Royal College of Surgeons has been awarded to Mr. Paterson Ross for his essay on "The Surgery of the Sympathetic Nervous System." This distinction has often fallen to Bart.'s men in the past, several members of the present Surgical Staff having won it in recent years. We offer Mr. Paterson Ross our heartiest congratulations on having added his name to this distinguished list.

* * *

BRITISH MEDICAL ASSOCIATION, 1832-1932.

This year is the Centenary of the British Medical Association, which has a membership of 34,000, distributed in 100 branches and 250 divisions throughout and beyond the Empire. The great extent of its work for members of the medical profession makes it one of the outstanding medical associations of the world, and in Tavistock Square it has a headquarters worthy of its prestige.

In July the Association will hold in London its Centenary Meeting, the programme for which has been published in the *British Medical Journal*.

The following St. Bartholomew's men, amongst others, hold office or will be taking part in this Hundredth Meeting:

Honorary Organizing Secretary: Dr. E. A. Worley.

Medicine.—President: Sir Humphry Rolleston, Bt., G.C.V.O., K.C.B., M.D. Vice-Presidents: Arthur J. Hall, M.D., F.R.C.P., Sir Thomas Horder, Bt., K.C.V.O., M.D.

Surgery.—Vice-Presidents: W. McAdam Eccles, M.S., F.R.C.S., G. E. Gask, C.M.G., D.S.O., F.R.C.S. Honorary Secretary: R. M. Vick, O.B.E., M.Chir., F.R.C.S. Discussion: Kenneth M. Walker, F.R.C.S.

Obstetrics and Gynaecology.—Honorary Secretary: Wilfred Shaw, M.D., F.R.C.S.

Physical Medicine.—Vice-Presidents: E. P. Cumberbatch, M.B., M.R.C.P., Sir Henry Gauvain, M.Ch., F.R.C.S. Discussion: E. P. Cumberbatch, M.D., M.R.C.P., Sir Henry Gauvain, M.Ch., F.R.C.S., C. B. Heald, C.B.E., M.D., M.R.C.P.

Public Health.—President: Sir George Newman, K.C.B., M.D., F.R.C.P.

Oto-Laryngology.—Vice-President: Sir James Dundas Grant, K.B.E., M.D., F.R.C.S. Hon. Secretary: F. W. Watkyn-Thomas, F.R.C.S.

Pathology.—Vice-President: E. H. Kettle, M.D., F.R.C.P. Discussion: E. H. Kettle, M.D., F.R.C.P., A. F. S. Sladden, M.D.

Bacteriology.—Vice-Presidents: S. R. Douglas, M.R.C.S., M. H. Gordon, C.M.G., C.B.E., M.D. Discussion: S. R. Douglas, M.R.C.S.

Radiology.—Vice-President: N. S. Finzi, M.B. Hon. Secretary: W. M. Levitt, M.B., M.R.C.P.

Diseases of Children.—Hon. Secretary: R. A. Ramsay, M.Chir., F.R.C.S. Discussion: Ogier R. Ward, M.Ch., F.R.C.S., R. H. Crowley, M.D., F.R.C.P., J. H. Thursfield, D.M., F.R.C.P.

Pharmacology and Therapeutics.—Vice-Presidents: A. J. Clark, M.D., F.R.C.P., F. R. Fraser, M.D., F.R.C.P., Philip Hamill, M.D., F.R.C.P. Discussion: R. R. Armstrong, M.D., F.R.C.P.

Physiology and Biochemistry.—President: Sir Henry Dale, M.D., F.R.C.P. Hon. Secretary: Reginald Hilton, M.D., F.R.C.P.

Ophthalmology.—President: Sir J. Herbert Parsons, C.B., M.B., F.R.C.S. Vice-President: R. Foster Moore, O.B.E., F.R.C.S. Discussion: R. Foster Moore, O.B.E., F.R.C.S., C. M. Hinds Howell, D.M., F.R.C.P.

Orthopaedics.—Vice-Presidents: R. C. Elmslie, O.B.E., M.S., F.R.C.S., E. W. Hey Groves, M.S., F.R.C.S. Discussion: R. C. Elmslie, O.B.E., M.S., F.R.C.S.

Anæsthetics.—Vice-President: C. Langton Hewer, M.B., B.S.

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Medical Sociology.—Honorary Secretaries: L. G. Glover, M.D., N. E. Waterfield, M.B., F.R.C.S.

Comparative Medicine.—Vice-President: J. A. Arkwright, M.D., F.R.C.P.

In view of the attendance of members from all over the Empire, and of delegates from foreign medical bodies, as well as of specially invited guests from foreign countries, the London meeting in July 1932 is likely to be of international importance.

* * *

ST. BARTHOLOMEW'S HOSPITAL WOMEN'S GUILD.

The Guild is to be congratulated in securing for the Annual View-Day Meeting the patronage of the Lady Mayoress, and the services of Major Ian Hay Beith, C.B.E., M.C., as chief speaker. The name of Ian Hay is familiar to everyone. Many of us have read his address to the students of Guy's Hospital some years ago, and were charmed by the wit and wisdom it contained. The ladies of the Guild are anxious to have as large an audience as possible. Students are invited to bring their visitors to the Great Hall on View Day, May 11th, at 4.15 p.m. Tea will be served at the end of the meeting.

We feel that the object and work of the Guild are not sufficiently well known in the Hospital. The Guild Committee are therefore anxious to enlist the interest and co-operation of all present Bart.'s men, and through them of their relations and friends, in the work which is being undertaken.

* * *

The Athletic Club will hold their Annual Sports at Winchmore Hill on Wednesday, May 25th. We are asked by the Secretary to draw attention to this date, as, in the past, attendance has always been strangely meagre. Students and their friends are invited to this important function, and are asked to give the Club their support. They will be sure of a good afternoon's

entertainment. The Club must be congratulated on winning the Inter-Hospital Cross-Country Championship so easily; this splendid success was due to fine team-work. They secured five of the first eight places—a record for this event.

* * *

The Fifth Summer Meeting of the St. Bartholomew's Hospital Golfing Society is to be held at Walton Heath Golf Club on Thursday, June 23rd, 1932. Through the kindness of Lord Riddell, members of the Society will be allowed to play without paying any green fee. Details of the competitions will be circulated in the early part of June. We hope that, if there is any Bart.'s man who is not a member of the Society, and is anxious to play at this meeting, he will communicate with Dr. Graham, 149, Harley Street, or Mr. Rupert Corbett, 91, Harley Street.

* * *

The Whitsun "meet" of the St. Bartholomew's Hospital Alpine Club will be held at the Pen-y-Gwryd Hotel in the Snowdon district on May 14th. Hospital men who intend to be present should inform the secretaries of the Club immediately, and state whether they wish accommodation to be reserved for them at the Hotel (at the rate of 16s. 6d. per day). It may be possible to arrange for some members to be taken by car, but, failing this, trains can be taken to Bettwys-y-Coed from Euston at 8.30 a.m., 10.30 a.m. and 11 p.m. (fare, 38s. 6d. week-end). Arrangements will be made to meet members at Bettwys-y-Coed station if the Secretaries are notified.

* * *

The Annual Past *v.* Present cricket and tennis matches will be played at Winchmore Hill on Saturday, June 11th. Old Bart.'s men who are cricketers and who wish to play for "The Past" should send their names as soon as possible to Dr. Geoffrey Bourne, 27, Harley Street. Sir Charles Gordon-Watson, 82, Harley Street, will be pleased to receive the names of those who wish to play tennis.

* * *

We are asked to remind readers that John Ridley Prentice, eldest son of the late Dr. Hugh Ridley Prentice, is a candidate for a Foundation Scholarship at Epsom College this year. At the last election he received many votes, but not sufficient to obtain him a scholarship. The support of Bart.'s men and any other readers, who may have unallocated votes in this year's election, is needed to bring about the happy result.

* * *

Our apologies are due to the *British Medical Journal* for having omitted to state in our last issue that the portrait of the late Sir Frederick Andrewes was reproduced by their kind permission.

§

A CASE OF SEVERE SEPSIS OF THE HAND, WITH SOME NOTES ON THE GENERAL TREATMENT OF SUCH CONDITIONS.



THE following case is of interest as illustrating the diagnosis and treatment of advanced septic conditions of the hand and forearm, and the value of the incisions advised by Kanavel in such cases.

CASE-NOTES.

History of present condition.—P. G.—, at. 4, was admitted to hospital with swelling and severe pain in the right hand and forearm. He had fallen down and scratched his hand four days previously.



FIG. 1.—PHOTOGRAPH TAKEN IN THE THEATRE BEFORE OPERATION, SHOWING THE ORIGINAL STATE OF THE HAND AND ARM. NOTICE THE SWELLING OF PALM AND WRIST, AND THE FLEXED POSITION OF THE FINGERS.

Condition on examination.—The child was obviously very ill. His temperature was 102.6° F. and his pulse-rate 116. The right hand (Fig. 1) was swollen and oedematous, with swelling both of the palm and dorsum. There were a number of superficial blisters on the dorsum of hand and wrist. There was also swelling and oedema of both flexor and extensor aspects of the forearm in its lower two-thirds. The little finger and thumb appeared to be more affected than the other digits. The skin of the whole of the lower forearm and hand was a dusky red in colour, and considerably hotter than the opposite side. On palpation the limb was extremely tender, and the oedema was found to be most marked over the dorsum of the wrist and hand. Tenderness was present over the lower ends of the radius and ulna, but the point of maximum tenderness was difficult

to determine, as the child cried whenever his hand was touched or moved in the slightest degree. For the same reason it was not possible to determine properly the range of movements at the wrist and finger-joints, although they were obviously limited. The epitrochlear gland was enlarged and very tender, but there was no enlargement or tenderness of the glands in the right axilla.

Operation.—This was performed almost immediately under a general anæsthetic. The hand and forearm were cleaned with ether and painted with picric acid. Incisions were then made as indicated in Fig. 2.

(1) The little finger was opened and the theca incised. Pus was found, and the incision was continued up the ulnar border of the hand so as to open the ulnar bursa. This was found to be infected only slightly, so that it was not counter-drained by incision above the wrist. This incision was also made to drain the main palmar space.

(2) The thenar space was then explored and a good deal of pus under pressure was found.

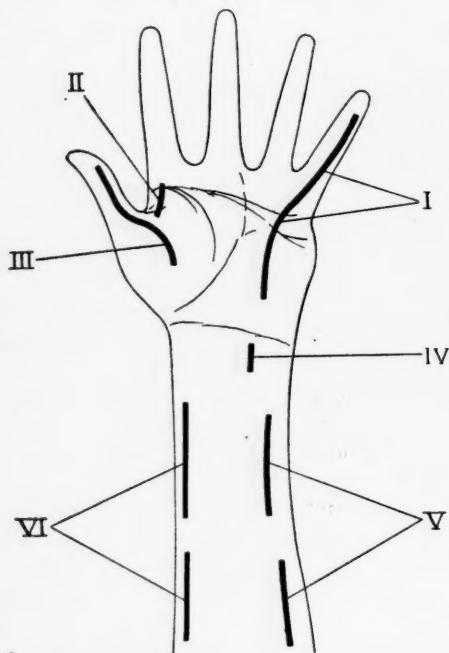


FIG. 2.—DIAGRAM ILLUSTRATING THE INCISIONS EMPLOYED IN THIS CASE.

N.B.—Incisions in figure numbered to correspond with the text.

(3) The tendon sheath of the thumb and radial bursa were then opened and a large amount of pus burst out under pressure.

(4) An incision for counter-drainage was therefore made above the wrist.

(5 and 6) The forearm was then drained by two lateral pairs of incisions. The whole of the lower part of the forearm was found to be distended by pus, extending between the flexor profundus muscle anteriorly and the interosseus membrane posteriorly, from the anterior annular ligament to the junction of the upper and middle thirds of the forearm. The wrist-joint did not appear to be infected.

In each case glove drainage was left in position, passing subcutaneously between adjacent incisions.

The whole hand and forearm were then wrapped in gauze soaked in flavine and paraffin; plenty of cotton-wool was applied and bandaged tightly to control any hæmorrhage which might take place. A straight splint was strapped on to prevent movement. On arrival in bed the arm was immobilized in a raised position on a pillow, between sandbags.

Post-operative treatment and progress.—The patient was given morphia gr. $\frac{3}{4}$ and continuous rectal salines. For the first twelve hours he was given as much fluid by mouth as he would take. After the first twenty-four hours he was given light diet, with extra fluids and a daily laxative. Full diet was resumed on the fourth day after operation.

The dressings were left undisturbed for twenty-four hours, as the temperature and pulse dropped after operation and the child seemed better. The arm was then dressed after a preliminary soaking in warm hypertonic saline. Very little oozing had occurred, but a good deal of purulent discharge was present on the dressings. The tracks between the incisions were irrigated with eusol, the incisions themselves dressed with gauze soaked in flavine and paraffin, and the



FIG. 3.—PHOTOGRAPH TAKEN RECENTLY, SHOWING THE PRESENT STATE OF THE HAND AND ARM. THE DESQUAMATING SKIN RATHER MASKS THE TRUE APPEARANCE OF THE LIMB IN THE PHOTOGRAPH.

splint reapplied. This was continued daily until the tracks closed and the wounds had almost healed.

On the fourth day the rubber drainage-strips were removed and the straight backsplint changed for a "cock-up" splint, providing about 20° hyperextension at the wrist-joint.

On the twenty-fifth day the incisions had so far healed up as to allow of massage and movements of the wrist and fingers to be commenced. The only exception was the little finger, which was still discharging pus, and in which part of the proximal phalanx appeared to be separating as a sequestrum.

At the present time (six weeks after the operation) movements of the wrist-joint are about 60% and of the fingers 40% of the normal. The hand (Fig. 3) is fairly normal in appearance, except for the scars of the incisions and the state of the little finger, which is still swollen and discharging sero-pus. The result is extraordinarily good, considering the original condition of the child on admission to hospital. The sequestrum has not yet separated from the little finger, but appears likely to do so in a few days' time.

CLINICAL TYPES OF INFECTION OCCURRING IN THE HAND.

Infections of the hand are grouped clinically into four recognized types:

(a) *Subcuticular*.—These are usually obvious, and are generally of little importance.

(b) *Subcutaneous*.—In this type the infection has spread to the pulp of the hand or finger, and is bounded by the partitions which subdivide this space. The skin of the terminal phalanges of the digits is closely bound down to the bone and periosteum by multiple fibrous septa, so that the subcutaneous space cannot expand to any extent in this situation. Hence inflammation and consequent rise of tension in this space are very likely to be followed by necrosis of most of the bone of the terminal phalanx, unless relieved by early and adequate incision. The base of the terminal phalanx, however, into which the deep flexor tendon is inserted, has a separate blood-supply from outside this closed space, and is therefore not involved in the general necrosis. The subcutaneous space in the hand is divided by the palmar fascia and its deep connections into three main portions: (i) The thenar space, laterally; (ii) the hypthenar space, medially; (iii) the intermediate main palmar space. But the deep fascia between the hypthenar and the main palmar space is only poorly developed, with the result that infection of either is generally accompanied by infection of the other. The thenar space does not extend into the forearm; but the palmar space extends upwards for about an inch above the anterior annular ligament, between the flexor profundus tendons anteriorly and the pronator quadratus posteriorly. Neither the palmar nor the thenar space communicates distally with the pulp of the fingers or thumb, so that infection can only spread from the latter to the subcutaneous spaces of the palm by way of the tendon sheaths.

(c) *Thecal*.—In this type infection of the tendon sheaths is present. It is a most serious condition, since pus spreads rapidly along the sheaths and may burst through them anywhere along their length, thus causing both infection of distant structures and possible sloughing of the tendons themselves. The tendon sheaths may be infected directly by spread from infection of the subcutaneous spaces, or by careless incision when opening up the latter. The tendon sheaths of the middle three fingers do not usually communicate with either of the palmar bursæ, whilst the tendon sheath of the little finger communicates with the ulnar bursa, and that of the thumb with the radial bursa. Both the ulnar and radial bursæ pass proximally into the forearm for about $1\frac{1}{2}$ in. and usually do not communicate.

But in a number of cases this arrangement of the sheaths varies from the normal—the radial bursa occasionally communicates with the ulnar bursa above the anterior annular ligament, and the tendon sheath of the index finger may communicate with the ulnar bursa. Hence infection of any of the digital tendon sheaths except those of the ring and middle fingers may cause infection of both palmar bursæ, extending up into the forearm.

(d) *Subperiosteal*.—This is really an acute periosteomyelitis, and generally causes local or total necrosis of bone underlying it. The infection may spread along the tendon sheath, and travelling along it manifest itself elsewhere.

THE DIFFERENTIAL DIAGNOSIS IN THIS CASE.

This case illustrates very well some of the more important points in the differential diagnosis of advanced septic conditions of the hand.

No initial focal point of infection was apparent, so the problem was to decide which of the clinical types of infection was present, and thus enable adequate incisions to be made without the risk of damaging uninfected structures. The patient was a child and in great pain, and thus unable to localize any point of maximum tenderness. The lower ends of the radius and ulna were very tender to the touch, and this raised the possibility of osteomyelitis of both bones as a cause of his condition. But the obvious advanced inflammatory changes in the hand and fingers rather suggested that the primary focus had been somewhere in the hand, and that the condition was one of severe sepsis of the latter rather than an initial bone infection. Moreover the extreme degree of swelling of the palm of the hand suggested that there was infection of the palmar space; as although swelling of the dorsum of the hand commonly occurs with an inflammatory condition of the forearm alone, swelling of the palm never occurs unless actual inflammation of the palmar space (or its contents) is present. There were no enlarged or tender glands in the right axilla, and this was rather in favour of a bone infection; although in cases of severe sepsis, if the resistance of the patient is low, the axillary glands do not always act in their usual capacity as a barrier to infection.

Thus it seemed evident that in this case the infection had originally started somewhere in the palmar space, and had spread distally by way of the tendon sheaths to the fingers, and proximally *via* the ulnar and radial bursæ to the forearm. This also explained the relatively increased septic condition apparent in the thumb and little finger, since the middle three digits

do not usually communicate with either of the palmar bursæ.

GENERAL TREATMENT OF SEPSIS AS ILLUSTRATED BY THIS CASE.

The treatment of septic conditions of the hand may be grouped under three main headings:

A. Pre-operative Treatment.

In the case described the condition necessitated immediate operation, so that no pre-operative treatment was performed. Such treatment consists essentially of resting the inflamed part and of the application of heat to it. The latter may take the form of hot fomentations applied frequently (the common custom of placing a hot fomentation—which only stays hot for about ten minutes—on the infected area and then renewing it every four hours is almost useless), hot poultices, hypertonic saline baths or radiant heat. The application of heat to the septic area increases the blood-supply to it, thus increasing the concentration of antibodies in the inflamed area. An alternative way of increasing the blood-supply to the inflamed part is by means of Bier's passive hyperæmia. The resting of the injured part is usually easy, as the patient is generally only too loth to attempt any movement which may cause him pain.

B. Operative Treatment.

The essential of operative treatment in all cases of sepsis is *free* incision, so as to provide adequate drainage. The incision should be as nearly as possible the whole length of the inflamed area, avoiding all important structures. This may appear drastic, but the rapidity with which such really properly drained tissues recover is amazing, if one only has sufficient moral courage to open them up really thoroughly. Very little bleeding usually occurs if the incision has been made in the correct place, since the blood-vessels are partially thrombosed, as a result of the sepsis. Such minor bleeding as occurs as a result of the incision may easily be controlled by firm packing after the operation, and in any case is of little importance compared with the beneficial results of really free drainage. If necessary, counter-drainage should be performed, two lateral incisions being made and connected subcutaneously by strips of glove drain. This method of drainage is particularly suited to cases such as subcutaneous whitlow of the finger, where a single median incision may involve risk of damage to the tendon; or where, owing to the area of the inflammation, one central incision would not alone provide adequate drainage.

Undoubtedly the best incisions for sepsis of the hand

and forearm are those advocated by Kanavel (see Fig. 4), nearly all of which were used in this case. Briefly they are as follows:

(a) *Infection of the distal phalanges.*—Cases of this type require immediate incision for the reasons stated above. A horse-shoe incision is made parallel to the nail and about $\frac{1}{8}$ in. anterior to it, and deepened to form a flap. Removal of the nail should be performed when there is pus below it; or two parallel incisions may be made running proximally from the supero-lateral angles of the nail, and the flap thus marked out reflected and held away from the nail by flavine and paraffin gauze.

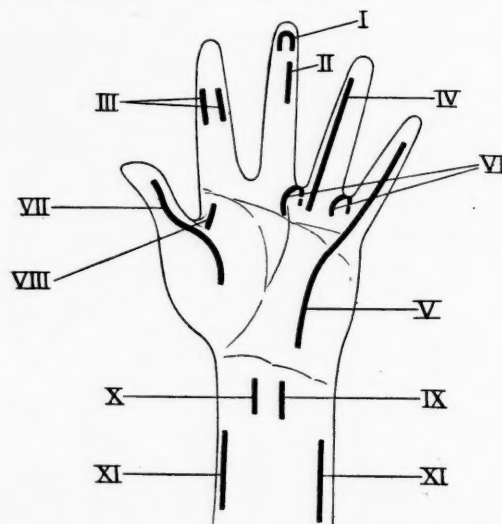


FIG. 4.—DIAGRAM ILLUSTRATING KANAVAL'S INCISIONS FOR THE TREATMENT OF SEPTIC HAND.

- (i) Horse-shoe incision for sepsis of terminal phalanx. (ii) Single antero-lateral incision. (iii) Double antero-lateral incision with counter-drainage. (iv) Incision for infection of tendon sheath of 2nd, 3rd and 4th fingers. (v) Incision for opening ulnar bursa and tendon sheath of little finger. (vi) Incisions for draining main palmar space. (vii) Incision for opening tendon sheath of flexor longus pollicis and radial bursa. (viii) Incision for draining thenar space. (ix) Incision for counter-drainage of ulnar bursa. (x) Incision for counter-drainage of radial bursa. (xi) Paired lateral incisions for drainage of forearm.

(b) *Infection of the middle and proximal phalanges.*—Either a single antero-lateral incision may be made or bilateral antero-lateral incisions with counter drainage. In either case care should be taken not to injure the tendon sheath if this is not already involved in the inflammation. If, however, the latter is involved, it should be split up from the side (for its entire length) so as to leave it as functionally perfect as possible, should the tendon recover.

(c) *Infection of the main palmar space.*—Antero-lateral horse-shoe incisions should be made deeply in

the web between the little and ring or ring and middle fingers, depending on the physical signs present as to the point of maximum tension. A pair of artery forceps is then passed along the deep surface of the lumbrical muscle into the main palmar space, and glove drain left in position. In severe cases these incisions may be supplemented by an incision running parallel to the ulnar border of the hand, over the hypothenar space.

(d) *Infection of the thenar space.*—Incision should be made in the web between the thumb and index finger, and parallel to it. Artery forceps should then be passed between the adductor transversus muscle posteriorly and the short muscles of the thumb anteriorly into the space, and glove drain left *in situ*.

(e) *Infection of the ulnar bursa.*—This usually occurs secondary to a whitlow of the little finger, and the tendon sheath of the little finger should first be incised for its whole length, as described above. This incision is then carried down into the ulnar bursa along the ulnar border of the hand, to the ulnar side of the flexor tendons, as far upwards as the distal margin of the anterior annular ligament. Should the infection have burst upwards through the proximal end of the ulnar bursa, the latter is opened by a vertical incision in the wrist above the anterior annular ligament, between the flexor sublimis digitorum and the flexor carpi ulnaris tendons. Counter drainage is then established by glove drain connecting the two incisions beneath the anterior annular ligament.

(f) *Infection of the radial bursa.*—The tendon sheath of the flexor longus pollicis should be opened up as described, and this incision should then be carried proximally upwards and inwards over the inner part of the thenar eminence, to a point about $1\frac{1}{2}$ in. below the lower wrist crease. It should not be carried further proximally than this, for fear of injuring the branch of the median nerve to the short thumb muscles. If the infection has burst through the proximal end of the bursa, an incision for counter-drainage is made above the anterior annular ligament between the flexor sublimis digitorum and flexor carpi radialis tendons, as described in (e) above.

(g) *Infection of the forearm.*—If infection has extended upwards into the forearm by extension from the palmar bursæ, lateral incisions should be made above the wrist, just anterior to the radius and ulna respectively, and adequate drainage established by glove drain passing transversely between the incisions, deep to the flexor profundus muscle. Care should be taken not to injure the radial artery (which crosses the radius about $1\frac{1}{2}$ in. above its styloid process) by extending these incisions too far distally.

All these operations are rendered much easier by the

previous application of a tourniquet. Tube drainage should never be used because of the danger of further damage to the already partially damaged structures in the inflamed area. The whole forearm and hand should always be splinted after operation, so as to prevent contracture from occurring, and in order to keep the injured part at rest.

c. Post-operative treatment.

The after-treatment of such conditions of the hand and arm is extremely important, and may be regarded under the following headings:

(a) *General treatment.*—This consists of the usual post-operative measures—rectal salines and morphia, or some other analgesic for the first twelve hours, then a light diet, increasing to full diet as soon as possible. It adds considerably to the patient's comfort if the hand and arm are elevated on a pillow between sandbags—at any rate for the first few days. It is important to give some aperient daily until the wound is healed, and extra fluids are also beneficial until convalescence is well advanced. As soon as the patient is able to take it, a tonic is advantageous; whilst the physical and psychical improvement resulting from the administration of a bottle of beer or stout a day to adult patients accustomed to it, has to be seen to be appreciated.

(b) *Treatment of the wound.*—If adequate drainage has been established, the dressing of the wound is rendered much easier. Daily or bi-daily dressings of eusol or of flavine and paraffin are the usual routine. If there is reason to suspect "pocketing" of pus, and in all cases of thecal infection, irrigation of the whole track of the wound with eusol and normal saline solution through a small-sized nasal tube or a soft rubber catheter is very useful. In some cases of severe sepsis continuous irrigation with Carrol-Dakin's solution may be necessary for a few days, to remove inaccessible sloughs. Secondary suture is rarely advisable in cases of infection of the hand, and in any case should only be performed when the organisms in a smear of the discharge have fallen to one or less per $\frac{1}{12}$ th microscope field. When sequestra are present, they should never be removed until they are completely free from the underlying bone, or more harm than good will be done to the surrounding tissues. In cases where there is a large clean granulating area, it is a good plan to dress the wound with the "tulle gras" dressing familiar to plastic surgeons, which reduces both the pain of the dressing and the likelihood of tearing off any of the delicate growing epithelial cells.

(c) *Restoration of function.*—Possible contractures of

the wrist and fingers are treated by prophylactic splinting from the time of operation; but if the correct incisions are made, trouble is very unlikely to arise from this cause. A much more common sequel of these cases of sepsis of the hand is stiffness and lack of movement of the damaged fingers, owing to adhesions between the tendons and the tendon sheaths, or between the tendons and surrounding structures. A good deal can be done to prevent this catastrophe by commencing gentle massage and movements as soon as the condition of the wound will allow; but even this treatment is not always successful. In such cases manipulation under a general anæsthetic (*not* nitrous oxide—which rarely provides sufficient relaxation for the purpose), with a subsequent course of massage and active movements, will often restore function to a considerable degree. If the digit in question still remains useless, and by its immobility prevents full use being made of the hand, the question of amputation arises; but this should never be performed within three months of healing of the wound, on account of the danger of infection of the stump occurring. Very grave consideration is necessary in the case of the thumb, as no portion of this digit can be sacrificed without considerable disability of the hand as a result.

In conclusion I wish to thank Mr. C. Naunton Morgan for his kind permission to publish the records of this case under his care at the Metropolitan Hospital.

DAVIS A. BEATTIE.

A CASE OF OBSTINATE CONSTIPATION TREATED BY SYMPATHECTOMY.

THE following notes are possibly of interest, not only on account of several unusual features of the case, but also as illustrating a line of treatment which is being employed at the present time with some measure of success.

Miss M. H—, a trained nurse, æt. 38, was admitted to Lawrence Ward on October 27th, 1931, complaining of (a) constipation, (b) diminished frequency of micturition.

History of the condition.—In January, 1928, following a subtotal hysterectomy, the patient noticed increasing constipation and abdominal distension. At this time she had her bowels open on alternate days with soap enemata, aperients, of which she tried a large variety and in large doses, being ineffective, with the sole exception of castor oil, which she was occasionally obliged to take.

Superimposed on this chronic obstruction, about once a fortnight she used to get attacks of acute abdominal pain, nausea and vomiting, associated with a slight rise of temperature to 99.6° F., the constipation becoming worse, so that even enemata produced a very poor result. The pain was colicky in nature, and situated mostly in the lower abdomen. The vomitus consisted of the previous meal and a brownish fluid, the whole attack lasting about 24 hours.

The patient also noticed that since 1929 she had been able to pass long periods without micturating, although her fluid intake was normal. Further, on questioning, it was found that she suffered considerably from coldness of the lower extremities, her feet particularly becoming white and quite painful in cold weather.

In July, 1931, she was admitted to Queen Mary's Hospital, Roehampton, for investigation and treatment. An X-ray taken there is alleged to have shown "the gut to be kinked and bound down." She was there for three months, during which time she was given many aperients and abdominal massage without any real improvement in the constipation, so she was discharged as incurable. Lord Moynihan, however, who saw the X-rays and notes, suggested surgical treatment, and sent her to St. Bartholomew's Hospital.

Her appetite was poor, she suffered with indigestion and flatulence, and had lost weight during the last few years. The bowels were open on alternate days with soap enemata, the result consisting mostly of scybalous masses and some mucus; no obvious blood. The micturition was quite normal apart from the diminished frequency.

Past history.—Scarlet fever and measles (æt. 6) in 1900. Acute appendicitis and appendicectomy without drainage (æt. 22) in 1916. She always had menorrhagia and dysmenorrhœa, which later became complicated by epimenorrhœa, so she was treated by Dr. Donaldson in Martha Ward as follows:

February, 1921: Ionization.

August, 1921: 25 mgrm. radium inserted into uterine cavity for twenty-four hours.

February, 1922: Right oöphorectomy.

These measures only gave a temporary improvement and, as the menorrhagia was not controlled by medical means, in—

November, 1929: A subtotal hysterectomy and partial left oöphorectomy were performed.

Family history.—*Nil ad rem.*

On examination she was seen to be thin and pale, but otherwise a healthy-looking patient. Temperature 97° F., pulse 60, respirations 20. The eyes were normal, the tongue clean and moist, and teeth showed no obvious sepsis. No enlarged glands were palpable in neck,

axillæ or groins. The heart and lungs were quite natural. Blood-pressure 120/85. The abdomen was symmetrical, but rather distended below the umbilicus. Right pararectal and left paramedian scars of previous operations were healthy. There was no visible peristalsis.

On palpation the muscle tone was poor and there was a marked aortic pulsation in the epigastrium. Tenderness was elicited in both iliac fossæ, but specially over the pelvic colon, which was easily palpable and indented on pressure. Cæcum was distended and hyper-resonant. Reflexes were natural, and no other enlarged viscus was palpable.

Per rectum.—Nothing abnormal discovered.

The feet were white and cold, but otherwise normal.

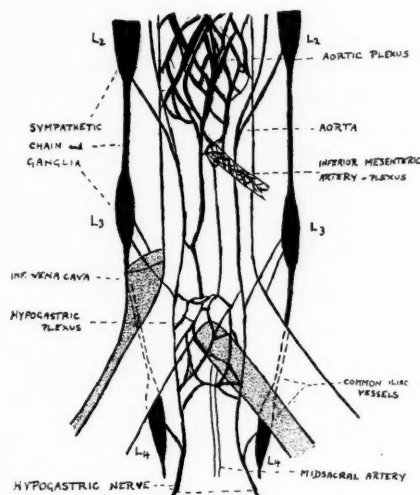


FIG. 1.—DIAGRAM OF SYMPATHETIC CONNECTIONS AS SEEN AT OPERATION.

Special examination.—The stool was a brown liquid, alkaline in reaction. It contained no undigested food and no occult blood; no starch granules.

Blood.—Red blood-cells, 3,860,000 per c.mm.; white blood-cells, 7250 per c.mm.

X-ray.—Report after barium meal: Enteroptosis; no evidence of adhesions.

A diagnosis of chronic intestinal obstruction, functional in nature, probably due to over-activity of the sympathetic, was made, the diminished frequency of micturition being only another manifestation of the same fundamental dysfunction.

On November 6th, 1931, an operation for lumbar sympathectomy was performed by Prof. Gask in Theatre G under general anaesthesia. The abdomen was opened by a right paramedian incision, 8 in. long, extending

from the pubes to $2\frac{1}{2}$ in. above the umbilicus. The table was then tilted into the Trendelenburg position and the pelvis explored, when it was found that there were numerous old adhesions between the small intestine and cæcum, on the one hand, and the cervical stump and the left ovary, which was cystic, on the other. These adhesions were divided, and the posterior abdominal wall exposed by retracting the small intestine and colon to the right and left respectively. The posterior parietal peritoneum was then incised to reveal the aorta, inferior vena cava and common iliac vessels. All the loose cellular tissue lying on the fifth lumbar and first sacral vertebrae at the bifurcation of the aorta was then dissected away, the middle sacral artery being ligatured in the process. The anterior surfaces of the proximal inch of the common iliac arteries and aorta itself, as far up as 1 in. above the origin of the inferior mesenteric artery, were then similarly treated, thus ensuring a complete removal of the pre-sacral nerves (hypogastric plexus), the commencement of the inferior mesenteric plexus and their numerous connections with the lumbar sympathetic ganglia, which were identified at this stage. Hæmostasis was secured, the table levelled and the wound closed in layers.

Following the operation there was a temporary rise of the temperature, pulse and respirations, to 100° , 110 and 40 respectively, but the patient was comparatively comfortable, the passage of a rectal tube being sufficient to relieve the slight flatulence of which she complained.

Thirty-six hours later she passed a normal motion for the first time in three and a half years. Micturition also became normal, the frequency increasing to 4-5/0.

The convalescence was uninterrupted, and she was discharged on December 1st, 1931, five weeks after admission, her bowels continuing to act normally once a day except for a few temporary remissions, lasting a day, which responded readily to a pill containing aloes.

DISCUSSION.

At first sight it might appear that the obstructive symptoms and their subsequent relief could well be explained by the adhesions found at operation, but these adhesions could scarcely have accounted for the micturition symptoms, so it seems more reasonable to ascribe a common origin to them, *viz.* a nervous disorder. Thus, although the case is not a true congenital dilatation of the colon as originally described by Hirschsprung, in that there is no evidence that the disease was congenital, while the colon, as seen at operation, and by radiography, was not markedly dilated, there are, nevertheless, certain marked similarities in the symptomatology and clinical findings,

while the fact that both conditions have been successfully treated by lumbar sympathectomy suggests that the pathology may be the same.

The exact nature of this or any other disorder of the sympathetic nervous system is not really understood, but a glance at the accompanying diagram, showing the distribution of the efferent pathways to the bladder and colon, will show how close is the relationship.

Briefly stated, the motor nerve supply of these structures is double:

- (a) Sacral autonomic (nervi erigentes or parasympathetic).
- (b) The sympathetic proper.

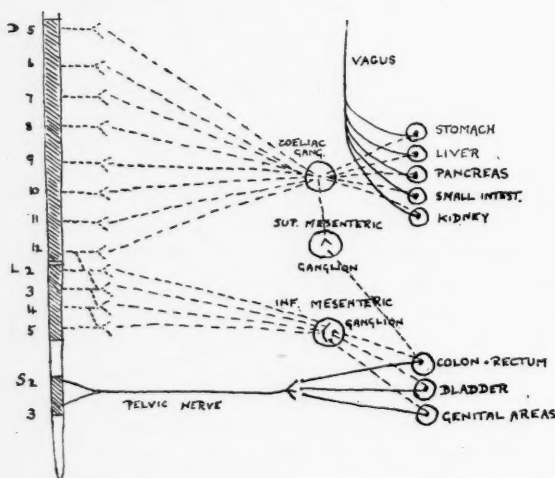


FIG. 2.—DIAGRAM OF AUTONOMIC NERVOUS SYSTEM IN THE ABDOMEN (MODIFIED FROM MEYER AND GOTLIEB). CONTINUOUS LINES = PARASYMPATHETIC; INTERRUPTED LINES = SYMPATHETIC.

(a) The efferent neurons leave the cord *via* the anterior primary divisions of the second and third sacral nerves, and are distributed *via* their visceral branches through the pelvic plexuses to plexuses in the wall of the viscera, which they supply, where the effector neuron arises.

(b) The sympathetic fibres going to the rectum and bladder are derived from the hypogastric plexus (presacral nerve) lying at the bifurcation of the aorta. This plexus has three roots (1), which derive their fibres from—

- (a) The semilunar ganglia.
- (b) Periarterial renal plexuses.
- (c) Intermesenteric or aortic plexus.
- (d) The first and second lumbar ganglia.

The nerve then divides into the two hypogastric nerves, which pass into the pelvis to the lateral wall of the rectum to form the hypogastric ganglia, which are

joined by small communicating rami from the third and fourth lumbar ganglia. Numerous fibres then pass forwards to the wall of the rectum and bladder. The colon receives its sympathetic nerve supply from the inferior mesenteric plexus, which is a direct continuation of the intermesenteric (aortic) plexus, and is formed by branches from the semilunar and aortico-renal ganglia. The segmental origin of these fibres is not definitely known, but probably extends from the fifth dorsal to the fourth lumbar.

It will be remembered that in experiments performed on dogs, stimulation of the sacral autonomic or nervi erigentes supplying the bladder causes contraction of the detrusor muscle and relaxation of the sphincter vesicae, thus emptying the bladder; while stimulation of the hypogastric nerves causes relaxation of the detrusor and contraction of the sphincter. Similar results can be obtained with the colon and rectum, although in these cases the contraction of the pelvic-rectal and internal rectal sphincters is not so marked (5). More recently similar experiments have been carried out on patients at the Mayo Clinic. Learmonth, who made the observations, noted the result of faradic stimulation of the presacral and hypogastric nerves during operations, while an assistant simultaneously recorded the effect on the bladder musculature by cystoscopy. Briefly summarized, he found that faradic stimulation of the presacral nerve caused—

- (a) Contraction of the ureteric orifices.
- (b) Contraction of the internal sphincter.
- (c) Increased tone of the trigone.
- (d) Contraction of the blood-vessels in the bladder-wall.
- (e) Contraction of the prostatic musculature and seminal vesicles.

When the hypogastric nerve on one side only was stimulated the results were almost identical, except that the contraction of the ureteric orifice was ipsilateral only.

Stimulation of the central cut end of these nerves gave rise to no observable phenomena, except that the patient, who was under spinal anaesthesia, but did not know what was being done, complained of a "crushing" pain, which he referred to the bladder. This is of interest, as it suggests the presence of sensory fibres in these nerves, and explains the rationale of sympathectomy as a palliative measure in the treatment of intractable bladder pain.

In none of these experiments, however, did he notice any marked change in the tone of the detrusor muscle, and as more elaborate tests were not feasible in the operating theatre, he carried out further investigations, using himself as the subject.

Having passed a catheter, he connected it to a manometer containing a column of fluid, which gave a measure of the intravesical pressure. An intravenous injection of 0.7 c.c. of 1 in 1000 adrenalin then led to an immediate active dilation of the bladder, as shown by a drop in the level of the fluid in the burette. This lasted approximately five minutes, and the pressure then rose suddenly, giving him an intense desire to micturate.

Section of the sympathetic nerves supplying the bladder, however, does not cause any noticeable change in the tone of the detrusor muscle, the immediate relaxation of the trigone and internal sphincter which does occur soon passing off, leaving an apparently normally functioning bladder. Learmonth, however, reported a case (1) in which disease of the sacral region of the cord, involving second and third sacral segments, from which the parasympathetic arises, led to paralysis of the detrusor, so that the patient had to be catheterized three times a day for five years—a condition which was relieved completely by section of the presacral nerve. This seems to prove that the sympathetic contains inhibitory fibres, which either by over-activity, or else by unrestrained activity due to paralysis of the parasympathetic, cause decreased frequency of micturition or even actual retention of urine.

In the case under discussion, however, although the onset of the symptoms soon after a pelvic operation (hysterectomy) at first sight suggested that there might be some association, such as damage to the parasympathetic leading to over-activity of the hypogastric nerves, actually this cannot be so, as damage to the nervi erigentes, such as might occur in a pelvic operation, could not account for the constipation; and, moreover, it is almost certain that the patient post-dated the onset of her symptoms, as reference to her old notes showed that there had been difficulty in getting the bowels open during her previous admissions some years before.

The exact pathology underlying this postulated sympathetic over-activity cannot be surmized, and although much work has been done on the subject, a satisfactory conclusion has not yet been arrived at.

Von Noorden (2) (1892), amongst others (Judd and Adson) (4), regards faulty autonomic balance as a visceral neurosis associated with, or closely allied to, neuroses of other types, as psychic and emotional disturbances of a purely functional type may result in parasympathetic or sympathetic hyperexcitability. Thus it is a well-known fact that hyperthyroidism, in which there is a marked increase in the sympathetic irritability, may be precipitated by worry or mental stress, suggesting that there is some connection between the

autonomic centres in the subthalamic region and the cerebral cortex.

The ductless glands have also been regarded with suspicion in functional defects of the involuntary nervous system (3), and although there is a tendency to ascribe many conditions in which the aetiology is not clear to endocrine disturbances, it would almost seem as if in this case the suspicion were justified, as it is significant that the patient suffered for many years from menstrual disorders, for which no definite pathological cause was found. Whether the nervous manifestations are the result or cause of the endocrine disturbance is, however, not clear.

It has been repeatedly shown, however, that alteration in the acid-base balance of the blood leads to changes in the delicate relationship normally present between the sympathetic and the parasympathetic nervous systems, so that the effect of adrenalin on the blood-pressure is greatly reduced after the administration of calcium chloride, which shifts the acid-base balance of the blood towards the acid side (2). Clinical observations support these findings, as it has been found that patients suffering from diseases commonly associated with hyperchlorhydria, such as bronchial asthma, diabetes insipidus and chronic peptic ulceration, seldom show any increased sympathetic activity to adrenalin, while patients with hyperthyroidism, in whom the increased sensibility to adrenalin is well known, exhibit a shifting of the acid-base balance towards the alkaline side. Conversely, Fokin (1925), Lande (1926) and Balint (1927) have shown that chronic duodenal and gastric ulcers are associated with vagotonia and hyperacidity in about 75% of cases, although the hydrogen ion concentration of the blood does not deviate beyond physiological limits.

Histo-pathology, however, still lags behind biochemistry, as profound morbid changes may occur in conditions like exophthalmic goitre and Raynaud's disease, without any definite demonstrable change in the cytology of the vegetative nervous system. It is, nevertheless, known that severe toxæmias do affect the sympathetic, causing at first an increased excitability, which later goes on to hypotonia in the terminal stages of the disease. This is particularly seen in tuberculosis, which in the later stages demonstrates vagotonia, the hectic flush and relatively slow pulse found even during pyrexial periods being explainable by parasympathetic predominance (2).

Moreover, it is well known that some acute infections, such as enteric, are accompanied by marked vagotonia, as shown by a slow pulse, which cannot be increased in frequency even by comparatively large doses of atropine, tachycardia, when it occurs, making the prognosis

grave. In scarlatina, on the other hand, the rapidity of the pulse-rate is out of all proportion to the pyrexia—a clinical observation which still awaits a satisfactory explanation.

Autonomic disorders have been put forward as the cause of many conditions, the list ranging from Raynaud's disease, causalgia and scleroderma peripherally, to such things as epilepsy, Graves's disease and bronchial asthma centrally, but the treatment by sympathectomy is, in many instances, purely empirical and the list is gradually being revised, as it is becoming increasingly clear that very often the autonomic nervous manifestations are secondary to a more fundamental factor.

The surgery of the autonomic nervous system is still in its infancy, and will, probably, in future years be entirely replaced by less radical means, but until the factors which govern the functional activity of the "sympathetic" are better understood, it offers the best, if not the only means, of treating an increasing number of conditions which have in the past baffled physicians and surgeons alike.

As early as 1889 Jobulay and Alexander (2) treated epilepsy by bilateral superior cervical ganglionectomy, since when most of the autonomic system has been removed by different operators in the treatment of diseases as numerous as they are divergent in their manifestations. The results, unfortunately, were often indifferent—a fact which led sympathectomy into some disrepute; but there is at present a recognized number of diseases which are definitely ameliorated by this form of treatment, which is once more coming into its own. The credit for adding Hirschsprung's disease to the list goes to Royle (1927) (6), who was the first to observe that some cases of constipation could be cured by lumbar sympathectomy. In a series of 25 patients on whom he performed this operation for congenital spastic paraplegia, he noticed that 13 suffered from obstinate constipation, which was subsequently relieved in 11 out of the 13. Consequently, in 1929, working in conjunction with Wade (7), he treated 5 cases of megalocolon by lumbar sympathectomy with such encouraging results that many other operators (4) have since followed his example, and this form of treatment has practically replaced the severe and extensive colectomy which was formerly advocated for this intractable condition.

It is quite obvious, however, that the success of the operation depends not only on the technical skill of the surgeon, but also on his clinical acumen in selecting suitable cases. A lumbar sympathectomy would scarcely be justified if medicine could achieve the same results, for in this instance, at least, surgical interference should only be resorted to when medical means have failed.

I have to thank Prof. Gask and Dr. Donaldson for permission to publish these notes, and Mr. J. Paterson Ross for many helpful suggestions.

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J. R. BLACKBURNE.

ROBERT KOCH.

Opening Address at a Symposium on "Robert Koch: the Man, the Years, the Harvest," held on March 11th at the East London Children's Hospital, under the Chairmanship of Sir Percival Hartley, C.V.O.

MANKIND, Sir, may conveniently be divided into two classes: that blessed minority who by the grace of Providence are privileged to speak before you, and the ill-starred majority who for their sins must needs speak after you. How salutary and indeed how amusing to contrast their inarticulate striving after expression or their empty rhetoric with your effortless and exquisite flow of words, the arresting suavity of your voice, and the rich sparkle of your happy thoughts. Be that as it may, I am here to-night to open a symposium on "Robert Koch: the Man, the Years, the Harvest." Now the term "symposium" is derived from two Greek words meaning "to drink together," but all I can see before me at the moment is a decanter filled with what looks to me like water.

Those of you who read your Bible earnestly will recall that there was only one man who asked for water, and he was in Hell. Indeed, it is improbable that water was ever intended for human consumption. Is it not described in Scripture as something with which only the wild ass quencheth its thirst?

Half a century! A lifetime for the individual who measures his folly and bliss in mathematical terms of hours which swell into years. Half a century! But an incident in the austere life of an institution such as this, whose arteries were hard and whose hair was grey long before you and I had been given a chance to waste time. Half a century! A raindrop evaporating on the eternal rock of history.

It is the evening of March 24th, 1882. The lecture-room of the Physiological Society at Berlin is crowded. In the chair is the University Professor of Physiology, du Bois Reymond, of fresh complexion and athletic frame, of whom it was said that he succeeded in accomplishing the seemingly impossible: he wrote scientific German with the elegance and precision of the French. Among the audience you will notice many whose fame has echoed down the Corridors of Time. You will have no difficulty in spotting the slight, elastic figure of Rudolf Virchow with the fiery eyes. It was he who turned men's thoughts to the individual cells rather than the tissues as the seats of disease. Thus he is the Father of Cellular Pathology. Yet how upset he was, perhaps just a trifle annoyed when he saw his disciples triumphantly invade his battlefield with their heterodox doctrines of bacteriology. There is Paul Ehrlich, in those days a young and obscure worker, to whom we owe the modern method of staining the tubercle bacillus. There is Löffler, a surgeon in the Prussian Army, who discovered the cause of swine-erysipelas and of glanders, but is best known to you as one of the two men who isolated the organism responsible for diphtheria, the Klebs-Löffler bacillus. On the platform stands a small, serious-looking man, with a short pointed beard and gold-rimmed spectacles. His voice is quiet, his story modest and plain. The epoch-making events of the world are seldom dramatic; only the things that do not really matter are trumpeted to the four corners of the earth. He tells his audience that he has discovered the cause of consumption, of tuberculosis, the tubercle bacillus. There is no discussion: for there is nothing to say. The paper is a model of accuracy and completeness, the experiments are conclusive, the arguments unequivocal. His name is Robert Koch: and none more resounding in the history of medicine.

While we leave this distinguished assembly to collect their hats and coats, let us from the dizzy

height of our intellectual superiority take a bird's eye view of Koch's life and achievements. Born on December 11th, 1843, at Klaustal, in Hanover, one of thirteen children of a mining engineer, he studied medicine in the University of Göttingen, and after taking his doctor's degree in 1866, became a general practitioner in the country. He could not afford the luxury of an academic career. Besides, he wanted to get married. He spent eight years in Wollstein, a God-forsaken little place in Posen, where he was busy enough. He had to ride on horseback through the mud to see a child choking with the diphtheria. How he felt his inability to help as rottenness in his bones! But how could he interfere if he did not even know what caused the disease?

In Paris at that time there was a lunatic at large who shouted from the housetops that microbes were the cause of consumption. Against this cracked evangelist who was not even a medical man the whole French army of medicine rose in a body and spat ridicule and contempt. His name Louis Pasteur. But as the result of his preaching, Koch called in the local carpenter to put up a partition in his consulting room. In one part he saw his patients, the other he used as a laboratory where he kept his microscope and mice. Busy all day with his professional duties, in the evening he hurried through supper, grunted good-night, and shut himself up in his laboratory. From his wife who saw little of him he received no encouragement. All she could say was "Robert, how you smell!" In 1880 came promotion. How refreshing it is to come across an instance in medicine of a stone that is fit for the wall and is not left lying in the road. Koch was called to Berlin to the Imperial Health Office, which put at his disposal a fine laboratory and trained assistants. In due course he discovered the smallest but most deadly enemy of the human race, the tubercle bacillus. Next day the world is full of his fame. People mention him in the same breath as Cæsar and Napoleon and call him "Privy Councillor" and "Excellency." Honours are showered upon this modest little man who is forced to attend receptions and eat enormous dinners which give him indigestion.

In 1890 Koch announced to the International Medical Congress at Berlin that he had found a cure for tuberculosis—tuberculin. No declaration of war could have caused wilder excitement. The telegraph wires carried his words to distant lands. There was a pathetic rush of consumptives by train or ship for Berlin, the Mecca of suffering mankind.

A very old man sits by the window and watches the snowflakes fall, softly, silently, covering the earth and hiding her many ugly scars. He is cold. He shudders.

A spasm shakes his body. He coughs. He spits bright blood into his handkerchief. His eyes are hollow, his lips parched, his nose sharp, his temples sunken. For many years he has been waiting for Death, but that grim jester who comes too soon to most men has forgotten his existence. His wife, too, has been waiting patiently these many years. She does not like the sight of blood. It makes her feel ill. Time has changed her love to indifference, to aversion. There is a knock at the door. The very old man shudders. Is it at last the bony knuckle of Death? Will they come now to wash his body, to tie up his jaw, to carry him out of the house in a long narrow box, with his hard-faced widow muttering her grim farewell: "Surely, a bloody husband wert thou to me"? The knock gets more vigorous, more triumphant. The door opens. There enters a small, serious-looking man, with a short pointed beard and gold-rimmed spectacles. It is Robert Koch, wearing the halo of the Messiah. "Come unto me all ye that are weary . . ." And behold! new life is poured into the very old man's hollow eyes, his dry lips glow afresh. He goes down on his knees. He who has long ceased to believe in a personal God thanks the Almighty for sending this Saviour. Poor fool! save your breath, save your prayers. The Messiah indeed is a false prophet who has promised more than he can keep. It is perhaps natural that we who could never hope to discover a new bacillus ourselves should frown upon tuberculin as the one great folly of this great scientist. No doubt he was persuaded against his better judgment to publish his research too soon. Yet posterity cannot shut its eyes to the fact of his grave responsibility. His rash and boundless enthusiasm led many foolish old men to risk travelling to Berlin in a biting northern winter. Some never reached Mecca alive. In many cases there was no improvement whatever. There were a number of unexpected deaths which tarnished the splendour of Koch's fame.

In addition to the tubercle bacillus, Koch discovered the organisms responsible for anthrax, cholera, and Egyptian ophthalmia.

In 1893 he left the wife of his youth to live with one who had charm and sympathy to offer him. This action of his led to much harsh criticism which he bore with dignity. He died of heart-failure on May 27th, 1910, at the aged of 67, at Baden-Baden, that tragic health-resort, which has witnessed the last days of some of the world's most famous men. His first wife lived on for three years, obscure, lonely, bitter.

Personally Koch was shy and reserved but he could be polite, even charming, unless he was overworked.

Just one final story before I sit down. In 1908 he

went to Washington to attend the International Tuberculosis Congress. On landing he was pounced upon by reporters who asked him "Well, Doctor, and what do you think of the future of medicine?" Koch was furious, and when annoyed he did not select his words very carefully. He is recorded to have addressed the gentlemen of the Press as "Lice-pickers."

W. R. BETT.

ABERNETHIAN SOCIETY.

THE Summer Sessional meeting was held on Thursday, April 14th, in the Medical and Surgical Theatre, the President, Mr. Kersley, being in the Chair. Prof. Hugh Cabot gave an address entitled "Hunting with a Movie Camera in Northern British Columbia."

The feature of the address was the series of beautiful films which were taken by the lecturer during his annual summer holiday on the tributaries of the Frazer River. Prof. Cabot, in his opening remarks, said how delighted he was to be back again within the walls of Bart.'s, of which, as a perpetual student and an honorary member of the Abernethian Society, he was highly proud. The country in which the films were taken had a diameter of about 800 miles north and south, and 650 miles east and west; it lay between the North-West Territory on the west and Saskatchewan on the east, containing two main mountain ranges, of which the Rocky Mountain group were the best known. It also contained a long river, the Frazer River; it was on this river and its tributaries that Prof. Cabot had explored in regard to their natural history.

There were three methods of travelling in this country—by water, by dog sleigh and snow shoe, or by air. What a difference this latter method of travelling had made to these outlying parts of the world to-day! By water one travelled in light canoes, which needed skilful handling, and it was by this means that the Frazer River was traversed by the lecturer when the films were taken. Prof. Cabot apologized for the amateurism of the pictures, as he was not an expert photographer himself, but the best film, he said, had unfortunately been drowned during the sudden fright of one of his colleagues who was taking it. There were many difficulties to be overcome, as most of the animals shown had never seen a human being before and were difficult to photograph.

The first film introduced the grandeur of the Rocky Mountains as they were approached in the train; then the scenery changed to that of the Frazer River itself, with the canoe team prepared for their adventure. Moose were seen drinking and feeding on the banks of the river as the canoes paddled onwards. At this point the lecturer said that these animals were considered to be very savage by some people, but showed no evidence in his experience. The male moose was noticed to be much more inquisitive than its cautious mate, which preferred the security of its home to the public gaze of the camera—a very human touch. Beavers with their dams, geese, gulls and many other animals were seen while Prof. Cabot gave a running commentary on the animals and their habits, his imitation of the call of the moose being especially memorable. In the final film a moose was shot in mid-stream and the method of dissecting the head from the trunk illustrated; there were also scenes of camp life and of fishing, thus ending a most instructive lecture, which was loudly applauded by the large audience.

Mr. HUME, in proposing the vote of thanks, referred to the professional work of the lecturer, and said what a privilege it had been for him and other Bart.'s men to work at his clinic in America. The spirit of adventure which had been shown in the lecture to-night was carried throughout Prof. Cabot's clinical work, and all who came in contact with him could not help being stimulated by the refreshing atmosphere. Prof. Cabot exhibited the outlook of an explorer which had been handed down to him through the blood of his forefathers, John and Sebastian Cabot, and finally he said, "You may judge a man by the manner in which he spends his leisure hours." The vote of thanks was seconded by W. D. COLTART, who ably mentioned with what interest he had listened to the lecture, and said that he had every intention of visiting Whipsnade at an early date to try out "the call of the moose," which he had now learnt.

Prof. CABOT, in reply, thanked the audience for listening to him so patiently, and said what a pleasure it had been to show the films. The meeting was then adjourned.

STUDENTS' UNION.

STUDENTS' UNION.

The Annual General Meeting of the Students' Union was held in the Abernethian Room on March 18th, 1932, at 12.30 p.m. The President, Dr. J. D. Barris, occupied the Chair.

The following officers were elected for the year 1932-33:

President: Prof. E. H. Kettle.

Vice-President: L. B. Furber.

Hon. Treasurers: Dr. Wilfred Shaw, Mr. J. Paterson Ross.

Senior Secretary: A. J. Owston.

Junior Secretary: S. E. Furber.

Financial Secretary: K. A. Latter.

Constituency A: L. H. Buckland, A. H. Pirie, J. R. Robertson.

Constituency B: G. H. Ellis, H. L. Wolfe.

Constituency C: B. Rait-Smith.

Mr. L. B. FURBER proposed, Mr. J. H. HUNT seconded, a vote of thanks to Dr. J. D. Barris on his retiring after two years as President of the Students' Union, and thanked him for his great interest and help in the many activities of the Union.

Mr. Reginald Vick's resignation as Hon. Treasurer, after his long association with the Union of twelve years, was accepted with much regret, and a vote of thanks was expressed to him and Dr. Wilfred Shaw for their hard work in the interests of the Union.

Mr. A. J. OWSTON then proposed, Mr. J. H. HUNT seconded, a vote of thanks to Mr. L. B. Furber, the retiring secretary, who had served the Council so efficiently. All good wishes were extended to him.

This concluded the business and the Chairman adjourned the meeting.

A. J. OWSTON, *Hon. Secs.*
S. E. FURBER

RUGBY FOOTBALL CLUB.

ST. BARTHOLOMEW'S HOSPITAL V. MOSELEY.

Played at Winchmore Hill on March 12th. Lost, 16-3.

This was the last home match of the season, and as with all our fixtures with Moseley, was really enjoyable, the game being much more even than the score suggests.

The Moseley full-back played a magnificent game, in contrast to ours, who had rather an off day. This was unfortunate, as owing to close marking, the main method of attack on both sides was the short punt ahead over the three, which was done by Kingdon to a degree not warranted by the conditions.

Between the two packs there was nothing to choose except that Moseley were quicker in backing up.

We obtained an early lead by a blind-side try, the ball going quickly from Taylor to Kingdon, who drew the wing and passed to Powell, who got over in the corner. Moseley began to press and scored through Trentham, making it 3-3 at half-time.

Afterwards we were nearly always on the defensive, and Byrne and Davis scored tries for Moseley, which Hill converted, besides which he kicked a magnificent penalty goal from nearly half-way.

The sorrows of defeat were well drowned in the dinner that the two teams partook of afterwards.

Team.—C. W. John (*back*); J. D. Powell, L. M. Curtiss, A. H. Pirie, J. G. Youngman (*three-quarters*); J. R. Kingdon, J. T. C. Taylor (*halves*); W. M. Capper, E. M. Darmady, D. W. Moynagh, R. Mundy, J. D. Wilson, K. J. Harvey, J. M. Jackson, B. S. Lewis (*forwards*).

ST. BARTHOLOMEW'S HOSPITAL V. BRISTOL.

Played at Bristol on March 29th. Lost, 9-0.

This game was remarkable for being very pleasant in spite of being played in rain on a water-logged pitch, it being impossible at the end to distinguish anybody on either side.

Owing to exams, and injuries we could not produce a full team, but with the assistance of H. F. Wickert, P. L. Armstrong and W. H. E. James, managed to produce fifteen men; neither were Bristol at full strength.

We began with a rush into their "25" and continued to have a slight advantage all the first half, till Spilsbury kicked a penalty goal for Bristol (3-0).

The second half produced tries for Bristol through Spilsbury and Rigg, but also nearly produced several for Bart.'s, as the forwards

brought off some perfectly magnificent rushes, and were only stopped just before they reached the line.

Among the forwards, Darmady, Capper and Lewis were prominent throughout the game, while outside Powell and Nel both showed to advantage.

Team.—J. G. Nel (*back*); J. D. Powell, R. M. Kirkwood, W. H. E. James, P. L. Armstrong (*three-quarters*); J. R. Kingdon, J. T. C. Taylor (*halves*); W. M. Capper, E. M. Darmady, R. Mundy, B. S. Lewis, D. W. Moynagh, K. D. Moynagh, A. H. Grant, H. F. Wickert (*forwards*).

ST. BARTHOLOMEW'S HOSPITAL V. PONTYPOOL.

Played at Pontypool on April 2nd. Lost, 28-5.

We again had difficulty in raising a team, but with the aid of Messrs. James, Armstrong, Burrow and Dowell managed to get fifteen, though naturally a disjointed team.

The weather was kind, but the mud had not recovered from Easter and was quite exceptionally glutinous. Most of our troubles in the game were due to the elusiveness of their scrum-half, who evaded tackling and did not pass till he reached our fly-half, thus giving Pontypool a man over at the wing. Their advantage from this was further increased by some inco-ordination of tackling on our left wing. Consequently their right wing, Bodger, who played a very fine game indeed, managed to secure 5 tries for himself. He scored his first almost immediately after the start. Then we nearly scored from a forward rush. This was typical of the first half, and we were unlucky to be down as much as 11 points at half-time.

In the second half we did less attacking as we got the ball less. Armstrong injured his leg and was moved to back, James going on the wing and Nel coming up to centre. Pontypool collected 17 more points, and not till the last minute of the game did we score, by a movement in which Kingdon drew fly-half and centre; Kirkwood ran straight on through the middle and passed to Nel, who scored.

Team.—J. G. Nel (*back*); J. D. Powell, R. M. Kirkwood, W. H. E. James, P. L. Armstrong (*three-quarters*); J. R. Kingdon, J. T. C. Taylor (*halves*); H. C. Burrow, A. Barber, E. M. Darmady, R. Mundy, A. H. Grant, E. N. Dowell, W. M. Capper, J. W. Cope (*forwards*).

ST. BARTHOLOMEW'S HOSPITAL V. PLYMOUTH ALBION.

Played at Plymouth on April 9th. Lost, 39-3.

This was the first match of our tour, and we were without Capper, Taylor and Harvey and suffered accordingly, for the forwards, though managing to hold and sometimes push the heavy Albion pack, were almost completely unable to secure the ball for the outsiders. Consequently the outsiders spent the whole afternoon in trying to stem the Albion three-quarter movements, which started after nearly every scrum. They commenced scoring almost at once, and amassed 17 points before half-time.

Immediately afterwards the Albion fly-half was injured and they took a man out of their pack to complete the outsiders. On our side Wilson was injured and retired into the scrum, Masina taking his place. We then began to attack, and Prowse, catching the ball on the bounce from some loose kicking by the Albion forwards, ran straight for the line and scored, leaving the Albion standing on the other side of the field. This was our only attempt at scoring, while Albion kept up an incessant attack and continued to score, ending up at 39-3.

Team.—J. G. Nel (*back*); J. D. Powell, C. B. Prowse, A. H. Pirie, J. G. Youngman (*three-quarters*); J. R. Kingdon, J. D. Wilson (*halves*); E. M. Darmady, D. W. Moynagh, H. C. Burrow, J. M. Jackson, R. Mundy, B. S. Lewis, F. H. Masina, J. W. Cope (*forwards*).

ST. BARTHOLOMEW'S HOSPITAL V. REDRUTH.

Played at Redruth on April 11th. Lost, 12-3.

This game, as we now expect when we play Redruth, was unusually good. We started downhill with a terrific gale but a pleasant sun, and began pressing immediately. The forwards managed to heel the ball both often and cleanly and we appeared to be in for a good time. Soon, however, Curtiss was injured and had to go off. Nel was brought up to the "three" line, John going back and Masina scrum-half. Then the sun went in and we had snow. This made handling difficult, but Masina nearly managed to get over from a break-away near their line. Then by a quick heel and a rapid pass out by Masina, Kingdon contrived a good opening, and quick passing by Pirie to Nel allowed the latter to score. This was not converted, so we led 3-0. After an attack by the Redruth backs it was half-time.

The wind dropped and the sun returned. Redruth, obtaining the ball more often, became more dangerous, and eventually scored a good try. This was not converted, and so we were 3-3. Redruth continued to press, and eventually their back scored with a beautiful drop. They led, 7-3. A hailstorm then arose, with a terrific wind against us; we survived this, but night came on suddenly, and they scored almost unseen. They converted this, and the game ended 12-3.

Team.—J. G. Nel (back); J. G. Youngman, A. H. Pirie, L. M. Curtiss, J. D. Powell (three-quarters); J. R. Kingdon, C. W. John (halves); E. M. Darnady, D. W. Moynagh, E. E. Harris, R. Mundy, A. H. Grant, B. S. Lewis, F. H. Masina, J. W. Cope (forwards).

ST. BARTHOLOMEW'S HOSPITAL v. ST. IVES.

Played at St. Ives on April 12th. Won, 6-0.

This was a more decisive victory than the score suggests, as we were continually attacking, except for two periods, one in each half, when the scrum settled on our line and could not be moved for a very long time. We scored early on with a good passing movement, enabling Powell to get over. This was not converted. St. Ives were getting the ball from the scrum more often than we were, but our marking was so close that they seldom managed to do anything with it. The referee luckily differed from the crowd in the interpretation of the offside rule. Near the end Kirkwood after cutting through the centre passed to Powell, who scored again. This was not converted, and the game ended with a 6-0 victory for us.

Our tour perhaps should not be called successful after the start at Plymouth, but that it was extremely pleasant everyone on it will agree.

Team.—J. G. Nel (back); J. G. Youngman, A. H. Pirie, R. M. Kirkwood, J. D. Powell (three-quarters); J. R. Kingdon, C. W. John (halves); E. M. Darnady, D. W. Moynagh, E. E. Harris, R. Mundy, A. H. Grant, J. W. Cope, F. H. Masina, B. S. Lewis (forwards).

MATCH RESULTS.

	Played.	Won.	Lost.	Drawn.	Points.	
					For.	Against.
1st XV . . .	34	15	19	0	269	353
"A" XV . . .	33	23	8	2	404	272
Extra "A" XV . . .	20	6	13	1	169	271
"B" XV . . .	21	8	9	4	196	186
Extra "B" XV . . .	15	9	6	0	200	124
"C" XV . . .	16	6	9	1	160	195
Extra "C" XV . . .	12	5	4	3	134	154

SEVEN-A-SIDES.

The 2nd VII managed to defeat the Old Grammarians 8-5 on their ground while we were a man short.

We then played Sutton at Cheam, and were only defeated after extra time had been played.

The first VII were defeated unluckily in the 4th round by Westminster Bank.

ASSOCIATION FOOTBALL CLUB.

The Annual General Meeting was held in the Committee Room on Friday, April 22nd, 1932. The following officers were elected for the season 1932-33:

President: Dr. W. H. Hurlley.

Vice-Presidents: Sir Charles Gordon-Watson, Dr. A. E. Gow, R. Foster-Moore, Esq.

Captain: R. Shackman.

Hon. Secretary: A. H. Hunt.

Hon. Match Secretary: W. M. Maidlow.

Hon. Treasurer: D. R. S. Howell.

Committee: F. E. Wheeler, D. R. S. Howell, and W. M. Maidlow.

Captain, 2nd XI: W. A. Owen.

Hon. Sec., 2nd XI: E. E. Brown.

Captain, 3rd XI: H. S. Rassim.

Hon. Sec., 3rd XI: G. H. Darke.

ATHLETIC CLUB.

With the beginning of this month the track season opens in full swing. All during the winter a small band of hardy and possibly much misguided men, stumbling over the stickiest of ploughed fields, and floundering hopelessly through ice-cold water and farm-yard mud, struggle and strive against one another till either their hearts give out or their shorts are lost.

This winter they achieved their ultimate aim in winning the Inter-Hospitals Cross-Country Championships. Upon this splendid success they are to be heartily congratulated. But the matter does not rest there, for this hard-earned victory prognosticates an equally successful track season.

The cross-country club always supplies a most essential nucleus to the track section, and it may be said that the fortunes of both sections of the Athletic Club run very closely parallel to each other. A review of the last few years will make this quite clear.

The last time Bart.'s won the track championship was in 1925, when, mainly through the great work of H. B. Stallard, the Olympic Games runner, and the finest athlete Bart.'s has ever had, we beat Guy's by 84 pts. to 60. That year T. R. Griffiths won the 100 yds. in 10 sec. dead, to equal the record, while Stallard won the 880 yds., 1 mile and 3 miles, thereby securing 30 pts. himself.

The following winter Bart.'s cross-country team won the Inter-Hospitals championship by a substantial margin. From then onwards, both on the track and over the country, we just failed to win, being second every year but one.

In 1930 we showed a distinct improvement, however, being second to St. Thomas's by 10 points on the track, and again second to the same hospital by 23 points over the country.

In 1931 we were only 2 points behind them on the country, and were just beaten on the last event, again by 2 points, in the track championship last summer. It will be remembered that in spite of repeated endeavours to get together a tug-o'-war team, we were quite unable to produce an eight to "pull over" a scratch Guy's team collected from the spectators. Had we fielded eight men from the Rugby team, even without any training, we should have qualified for the Final, thereby gaining 3 points, which would have won us the championship. Let us hope that there will be a little help forthcoming from the "tough" men of some of the other clubs this summer.

For this year it is highly probable that we shall again annex the Shield which we have not seen for seven years. Our win over the country was so decisive as to leave very little doubt as to our summer prospects.

Among many new athletes we have with us K. W. Martin, the Cambridge pole-vaulter, who, in the absence of L. T. Bond, the St. Thomas's international and record holder, should undoubtedly secure us first place in that event. We are, however, very weak in the long jump, high jump and hurdles. Any new talent lying hidden in the Hospital is urgently asked to make itself known to any member of the Athletic Club. In the track events we are, as always, very strong, and we hope these men will pull us over the heads of St. Thomas's.

A very full fixture list has been arranged, including matches with Reading University and two of the Cambridge Colleges. A place in the teams will be found for any man who is keen and shows promise.

At the Annual General Meeting in December the following officers were elected:

President: Mr. Theodore Just.

Vice-Presidents: Dr. Morley Fletcher, Sir Charles Gordon-Watson, Mr. H. B. Stallard, Mr. Girling Ball, Mr. Reginald Vick, Prof. Gask, Dr. Adolph Abrahams.

Captain: J. R. Strong.

Hon. Secretaries: W. H. Jopling and J. W. Perrott.

Committee: K. W. Martin, J. Shields, G. D. Wedd, C. E. Goodhart, W. D. Coltart, R. J. Simcox, J. R. Hill, J. G. Nel.

FIXTURES FOR SEASON 1932.

May 12th.	Thursday.	v. Emmanuel College, Cambridge.	Home.
" 18th.	Wednesday.	v. Queens' College, Cambridge.	Home.
" 23rd.	Monday.	Heats for Annual Sports.	
" 25th.	Wednesday.	Annual Athletic Sports.	
June 1st.	Wednesday.	v. Westminster Bank.	Away.
" 6th.	Monday.	Heats for Inter-Hospital Sports.	
" 8th.	Wednesday.	Inter-Hospital Sports.	
" 20th.	Monday.	v. Reading University.	Away.
" 23rd.	Thursday.	v. Lensbury A.C.	Away.
" 29th.	Wednesday.	v. Barclay's Bank.	Away.
July 20th.	Wednesday.	v. Metropolitan Police A.C.	Away.

J. R. S.

THE ST. BARTHOLOMEW'S HOSPITAL ALPINE CLUB.

WHITSUN MEET.

At the inaugural meeting of the Club on November 4th, 1930, the President suggested the possibility of holding a club-meet somewhere in the English hills, with the idea of starting off the Club on that "active" basis which seems to be so desirable for the prosperity of such an organization. The Snowdon district was mentioned as being the most readily accessible from here.

The Hospital Alpine Club exists for the benefit of any members of the Hospital, either past or present, who are interested in mountaineering or ski-ing, or who love the hills. The objects of the Club may be said to be twofold. In the first place it affords opportunity for the social enjoyment of a common interest, so to this end three Club meetings are held throughout the year, at which members dine together, and hear a lecture or a paper read on some subject of mountaineering or ski-ing interest. In the second place, it seeks to stimulate a growing interest in the actual practice of mountain-craft. It is with this latter object in view that we propose to hold a club-meet in Snowdonia over the Whitsun week-end. The meet will be an excellent opportunity for anybody who feels that he is an embryo mountaineer to gain an introduction to the methods of hill-craft in a safe and pleasant manner.

The district chosen is the Snowdon massif, and it is proposed to arrange accommodation for the Club party at the Pen-y-Gwryd hotel. Members who wish to be accommodated with the party should inform the secretaries at the earliest possible opportunity. The hotel contains a billiard-room, and there is a certain amount of fishing (brown trout) in the neighbouring llyns and streams. There are other hotels in the district for members who wish to arrange their own accommodation. There are also facilities for camping.

Parties will be arranged for those who wish to rock-climb; less agile members will find magnificent fell and ridge walking. Among the mountains of the district may be mentioned: Snowdon, Crib Goch, Llwedd and the Glyders, whilst Tryfen is somewhat outlying. Botanists, geologists and ornithologists will have opportunity for field-work.

It may be possible to arrange for those members who have motor transport to find room in their cars for less fortunate persons.

With regard to equipment, old clothes, and, if you are going to climb, a pair of stout and properly nailed boots are the only essentials; but all information with respect to these and other details can be obtained from the secretaries of the Club.

We hope that any member of the Hospital who is interested in mountains and mountain-craft will come on the meet, where he will be welcomed.

C. B. M. WARREN } Hon. Secs.
R. G. ORR }

The next general meeting and dinner of the Club is due to be held some time in the middle of May. Notice of this meeting will be posted on the Students' Union screens shortly. The guest and lecturer at this meeting will be L. R. Wager, Geologist to the "British Arctic Air Route Expedition," and leader of the party which attempted the ascent of Mount Forel in Greenland.

CORRESPONDENCE.

"ON CHRONICS."

To the Editor, 'St. Bartholomew's Hospital Journal.'

DEAR SIR,—The short article about "Chronics" published in the last issue of the JOURNAL has the ring of truth and first-hand experience about it. The writer evidently is, or recently has been, a junior house physician. One can see him rather wearily leaving his box in the Surgery at one o'clock or after, drained of vitality, and worn out by the demands made on his strength and knowledge during his previous four hours' work. It is obviously too much for him. He is a sympathetic man, and the people who come to the Out-Patient Department of our Hospital are "sick in mind rather than in body." "No treatment is of the slightest avail." They waste the time of the medical and nursing staff. This too simple view of an important matter is emphasized by the approval given it in your editorial remarks.

But there is another aspect of the case which has to be taken into account. We are training the doctors of the future, not only among

our medical students, but also among the Resident Staff. The Visiting Staff are also learning. It is something new, surprisingly new, to learn that our aim should be "to restrict the use of the Out-Patient Departments as much as possible to emergencies and to those requiring consultants' opinions or special treatment." Emergencies, consultations, special treatment! Perforated gastric ulcers, dental sepsis, diathermy! Fractured bases, P.U.O., infra-red! I see the surgeon, the dental surgeon, consulting physician, oto-laryngo-rhinologist, ophthalmologist and physico-therapist. But where is the doctor? Where is the man who knows something of medicine and surgery, and something of men and women, the man who is a trusted adviser, and often a friend, too, of his patients? He is as much wanted as the others. He is the doctor of the past and of the future. May we not supply material for his education and experience in the Out-Patient Department of St. Bartholomew's Hospital?

Let me assure you, Sir, that the majority of those who attend our Out-Patient Department come for help. As "H. B." says, with true insight, many are sick in mind rather than in body. When he wants to extract their teeth they refuse, but possibly they know that the infection of their tooth-sockets is not the cause of their suffering. They do "not even trouble to read the label on the bottle," and, may I add, on arrival home they probably do not even trouble to draw the cork! And why? Perhaps it is because they think the bottle contains a tonic or a purge. The times are changing. Though we are very conservative in the medical profession and at Bart.'s, we must change with them. The veterinary surgeons are forging ahead of us. Recently a letter appeared on the front page of the *Times*, addressed to stock-owners who both love animals and make their money out of them. "Is it good enough?" "Is it kind?" "Is it fair," the writer asks, "to dose them so?" He is writing about giving horses tonics and purgatives indiscriminately. If horses cannot stand these things, is it surprising that some poor patients shirk them?

And yet these people get good from attending the Hospital. They get some support and satisfaction at least. It may be little they get, but it is little they want. There is probably nowhere else where they can get even the little offered at Bart.'s. Sometimes they want a little understanding and get sympathy or encouragement, or a medical problem is realized, isolated and recognized. And then, of course, there is the meeting of other friends and sufferers, there are the operations, dentists, X-rays and consultations, and the reputation of a Hospital that in times of far greater poverty, squallor and ignorance has done its best for those who asked its help.

Workers in the Out-Patient Department must keep a bright eye open for medical and surgical problems, because they are more often present than is thought, though a little indistinct and sometimes hidden by other things. In regard to patients who do not present a tangible problem of medicine or surgery, there is something more important in the people themselves. In the Out-Patient and Casualty Departments much can be learned about the people in the world. The practice of medicine "outside" is not unlike work in the surgery. There are a few emergencies, consultations and special treatments every day, every week or every month, according to the type of practice. But in every busy practice there is that insistent pressure of work (a pressure that sometimes threatens to swamp the worker when he is tired), which is so obvious in the work of the Surgery and Out-Patient Departments. The sooner the doctor, whether a student or not, learns, not only to cope with this pressure—this strain which is almost too great at times—the better for his education and his work in later years. And lastly, in his work in the Out-Patient Department, it goes hard with the man who mistakes his vocation. If he thinks he is there to make cut and dried diagnoses and effect clever cures, he is doomed to disappointment and failure. He must know, and work in the Surgery soon teaches it, that "medicine is not the art of curing diseases; it is the art of treating them, with the hope of curing them, and of soothing and satisfying sick people." Medicine has advanced since Corvisart doctored Napoleon, but his idea of medicine still has truth in it.

I am, Sir,

London, N.W. 1;
April 25th, 1932.

Yours faithfully,

GEOFFREY EVANS.

SIR,—I was so impressed by the folly of the chronics who waste our precious time that I decided to ask some of them why, if they are well, they go on attending the Hospital.

The first was a rheumatic old lady. She said that she was no better than when she first attended. Perhaps she was worse. I

pointed out that it was most illogical to keep on coming. She replied that she was so much worse when she stopped the medicine that she had to keep on with it. She could manage the journey on a fine day.

The next half-dozen were suffering from family trouble and indefinite ill-health, and over-work. The medicine gave them strength, and a kind word from the nice young doctor helped a little, and stopped them from breaking down completely. They had not enough money to pay a private doctor.

The next had once complained of constipation. Since coming to the Hospital she had not had a solid motion. She had now three motions a day, and hoped by perseverance to reach the state of grace of six!

I looked at the cards of a few more. They complained of aches and pains. The doctors had not found causes for them. Perhaps there were no causes. Anyhow, the patients suffered intensely from the pains. They felt, rightly or wrongly, that something was being done for them.

I tried to work out how many could be supplied with medicine for the price of an appendicectomy. I gave it up. It was a good many.

When I am a millionaire I shall endow a Christian Science Department to deal with these patients. Until then, I suppose things will have to go on as they are.

H. G. C. RHEO.

REVIEWS.

DIPHTHERIA, PAST AND PRESENT: ITS ÆTIOLOGY, DISTRIBUTION, TRANSMISSION AND PREVENTION. By J. GRAHAM FORBES, M.D., F.R.C.P., D.P.H., Principal Assistant Medical Officer, London County Council. With an Introductory Note by the late Sir Frederick Andrewes, M.D., F.R.S. (John Bale, Sons & Danielsson, Ltd., 1932.) Pp. xx + 832. 45s. net.

When the Medical Research Council Monograph on Diphtheria appeared some years ago it was generally felt that the last word had been said on this subject; at first sight the publication of another encyclopædic volume dealing with this disease is therefore somewhat surprising. In order to comprehend its purpose, it is necessary briefly to survey the history of diphtheria in the last forty years and the means which have been found to combat the disease. In this period the four principal achievements have been, successively, the introduction of antitoxic serum in treatment, the recognition of the carrier as the chief agent in spreading infection, the application of the Schick test for determining susceptibility, and the use of toxin-antitoxin mixtures and other preparations for the purpose of immunization. It is still by no means universally known that a series of three injections, producing little or no local reaction or constitutional disturbance, will confer immunity on a previously susceptible individual. This method of immunization may either be confined to Schick reactors, or applied indiscriminately without a previous test of susceptibility; it should, however, be succeeded by this test in order to determine that immunization has been successful.

A method is therefore available by which the risk of diphtheria can be reduced to a minimum. In this country it has been applied only in a limited number of centres, and there only to a fraction, sometimes small, of the child population. The latter half of Dr. Graham Forbes's book is occupied by an account of the efforts made in this direction, not only in this country, but in many other parts of the world, and his chief concern is clearly to urge more general, if not universal, prophylactic immunization—an aim which, as he briefly suggests in the last few lines of his book, calls not only for the assent and interest of local authorities, but for the provision of extra staff.

The earlier part of the book is devoted to a study of the distribution of diphtheria in England and Wales at different periods and in different localities, and to much shorter sections on "Ætiology" and "Transmission," which might well have been combined, since both deal with factors concerned in the spread of the disease, or supposed at some time to have had an influence in this direction. These complete the subject-matter, which is thus confined strictly to the province of the public health administrator. There is no discussion of treatment, no consideration of the disease from the pathological or bacteriological aspects (except an addendum recording the recent observation that *C. diphtheria* exists in two forms), and

no description even of the technique and pitfalls of the Schick test. The absence of these features is recorded, not as criticism, but in order that the reader may not look in these pages for what was not intended to be there.

As a compilation of accurate information the book is a monumental achievement, and it must become a standard work of reference which should be available for all public health officials. The only criticism on which we would venture is one which was doubtless in the mind of Sir Frederick Andrewes when he wrote in the foreword that he could wish the author had been "less sparing in his comments." It is exceedingly difficult for the reader to extract valid and general conclusions such as this imposing mass of data must be capable of affording, and the introduction of summaries indicating such conclusions, or commentaries emphasizing and interpreting the salient points in what has gone before, is almost indispensable to the reader seeking general guidance rather than any specific item of statistical information.

THE COMMONER NERVOUS DISEASES. By FREDERICK J. NATTRASS, M.D., F.R.C.P. London: Humphrey Milford, Oxford Medical Publications, 1931. Pp. 218. 2 coloured plates. 15 illustrations. Price 12s. 6d.

This book is designed for students and practitioners, to supply the necessary fundamental knowledge of neurology. The author, believing that difficulties in neurology arise more frequently from lack of knowledge of the variations in common diseases than from ignorance of rarities, has confined himself to the commoner nervous diseases, and has produced a very readable little text-book, which is by far the best introduction to neurology that we have seen. In the preliminary chapter on "Principles of Diagnosis," we are introduced to a clear and orderly method of history-taking and examination, illustrated by useful plates of the fundus oculi, photographs of the actual tests, and diagrams of the sensory and motor pathways. Dr. Nattrass examines first cranial nerves, then upper limbs, trunk and lower limbs. We feel that it is more conducive to orderly thinking to examine the parts of the nervous system in turn in some such order as this: Mental condition, cranial nerves, motor system (shape, size, active, passive and involuntary movements, co-ordination, cerebellar functions), sensory system, reflexes, posture, gait and cerebro-spinal fluid.

The subsequent chapters contain an account of the commoner nervous diseases and their variations, each type being illustrated by a brief case-history, and many valuable references given to recent original papers. Each account is admirably reasoned out, and the pathology of each symptom is indicated where possible. In the chapter dealing with syphilis the importance of the early sensory loss in tabes is very properly emphasized. Recent work on the pathology of this condition is well summarized. The treatment of dementia paralytica is very briefly dealt with, and no account of trypanamide is given. The chapter on epilepsy is the best in the book. Epilepsy is regarded as a symptom (as is chorea), which may appear in various conditions; the word "epileptiform" is abandoned. No mention is made of the treatment of epilepsy by ketogenic diet. The author might have stressed the point that epilepsy, starting in adults, is rarely idiopathic. The chapter on hemiplegia is far from complete, but includes a useful account of cerebral aneurysms.

Students who are confused in their ideas of epidemic encephalitis should read this account of it, the most clearly written exposition we have ever read of this protean disease.

The brief chapter on psycho-neuroses, admirably written as it is, might have been omitted, and an account of syringomyelia substituted.

The book can be recommended to students and practitioners with every confidence, although the information it contains will scarcely suffice for the final examinations.

FERTILITY AND STERILITY IN MARRIAGE. By TH. H. VAN DE VELDE, M.D. London: William Heinemann, 1931. Pp. xx + 448. 20 plates. Price 25s.

SEX HOSTILITY IN MARRIAGE. By the same author. Pp. xix + 296. 42 illustrations. Price 17s. 6d.

These two volumes complete Dr. Van de Velde's trilogy on "synousiology," the first book being the widely-read *Ideal Marriage*, which appeared some years ago. *Fertility and Sterility in Marriage*

deals with methods of achieving a desired pregnancy, causes and treatment of sterility, and finally, with enormous detail, the prevention of undesired conception. The sociological and ethical sides of contraception are discussed, and the views of the various religious sects are given and criticized.

Sex Hostility in Marriage deals with the whole problem of the unhappy marriage from the point of view of psychology. There are multitudinous references to other writers, scientific and otherwise, in both these books. The language is a curious mixture of scientific and non-scientific phraseology. The ovum is vibrating with "urges, needs and sensations," the zygote "writhes as though in parturition, a world in travail."

The amount of information contained in these two books is enormous; about half of it is interesting, and a twentieth part is practical. As a guide to married people these two books, for all their erudition, are inferior to the smaller books, whose name is legion. There is no doubt that a great deal of unhappiness and mental upset among married people can be attributed to ignorance of facts which they ought to have known. But these books will not relieve apprehension or give confidence; they are more likely to have the opposite effect, so complicated does "this woman business" appear.

As a guide to medical men the books are of some value, but the useful portion is diluted with so much unnecessary detail and periphrasis that the text provokes irritation and impatience. Many of his statements of fact are mere theory.

We have no doubt, however, that the books will find a good market among the lay public, if only for their illustrations. Dr. Van de Velde's reputation as a teacher would rest on a firmer basis had the last two legs of the tripod failed to materialize.

TEXT-BOOK OF GYNÆCOLOGY. BY SIDNEY FORSDIKE, M.D., F.R.C.S., B.S. (London: William Heinemann, 1932.) Pp. xii + 290, with 142 illustrations. Price 15s. net.

This is a stimulating little book, which is itself, among text-books of gynaecology, a rare virtue.

It is well laid out, and on reading through it fact upon fact is presented in logical sequence. The chapters are short, and thereby impress themselves the more readily upon the memory, and the illustrations, by Mr. Sewill, amply testify to his skill as a medical draughtsman. There is an excellent chapter on dysmenorrhœa; while on the vexed question of chronic metritis the author is discreet though lucid. A brief outline of the therapeutics of radium, with a short summary of the reasons for controlling its rays and their application to gynaecology, is very helpful.

Mr. Forsdike's views on the action of radium on the ovary and endometrium, and the mode of production of the artificial menopause, are contrary to those taught at this Medical School, but the facts supporting his views are well set out. He says: "Amenorrhœa usually ensues in 6-9 months—the question as to whether this result is due to direct action on the endometrium, or upon the ovaries, was examined by the author in a series of experiments upon the ovaries of cats. It was conclusively proved that the effect was entirely due to the endometrium, for at a distance of three inches, which is the distance of the normal ovary from the uterine cavity, no demonstrable change was found in the ovary, whereas the endometrium exhibited profound change."

This little book, then, can be thoroughly recommended to the student, as a nucleus around which he may build his knowledge of gynaecology, whether it be gleaned in the ward, on rounds, or in the out-patient department.

A TEXT-BOOK OF X-RAY THERAPEUTICS. BY ROBERT KNOX, M.D., C.M.(Edin.), M.R.C.S.(Eng.), L.R.C.P.(Lond.), M.I.E.E., D.M.R.E. Completed and edited by WALTER M. LEVITT, M.B., (Irel.), M.R.C.S.(Lond.), D.M.R.E.(Camb.), Medical Officer in Charge of the Radio-Therapeutic Research Department, and Assistant Medical Officer to the X-Ray Department, St. Bartholomew's Hospital, London. (A. C. Black, Ltd., 1932.) Pp. xii + 250 with 11 plates and 95 illustrations. Price 21s. net.

Although case-reports on the results of irradiation are becoming numerous, there has been a lack of general literature on this subject in England.

Dr. Levitt is to be congratulated on fulfilling so creditably the difficult task of rewriting and enlarging this comprehensive work. The first few chapters are devoted to a practical account of the physics of X-ray therapy, its dosage, and the biological effects of

irradiation. The new Chapter VIII on the principles of technique is particularly good, and the illustrations of this, and indeed those throughout the book are excellent. A chapter is given to the treatment of each system, including skin and blood diseases.

In the chapter on thyroid disease (XIX) there is a departure from the plan of the rest of the book in the shape of a description of the ætiology, signs and symptoms of Graves's disease; the need for this is scarcely obvious. Discussion of the relative positions of surgery and irradiation in therapy (pp. 130 and 136) are of great value.

None interested in medical radiology should fail to get this book.

A DESCRIPTION OF THE PLANES OF FASCIA OF THE HUMAN BODY. BY B. B. GALLAUDET. (London: Humphrey Milford, 1931.) Pp. 75. Price 14s. net.

The author considers that the fasciæ of the abdomen, pelvis and perinæum are inadequately described in our standard text-books, while most of us perhaps consider that already too much space is devoted to their description.

The present trend of anatomical teaching is to consider most fascial planes as artefacts produced at the will of the dissector, few being of practical importance.

In this book the author stresses the law of continuity of fascia, and proceeds to describe the common plane of fascia at first systematically and then regionally, confining himself to the abdomen, pelvis and perinæum. It seems a pity that the more interesting planes have been omitted, e.g. the intermuscular septa of the arm and the fascial compartments of the palm, which have some practical application, and description confined to regions which have little but academic interest.

The book is, doubtless, the outcome of much work and thought, but the descriptions are difficult to follow, and there is much repetition. Nevertheless there is contained in it a systematic and connected account of the abdominal fasciæ which may be of use to senior students of anatomy.

HANDBOOK OF SKIN DISEASES. BY FREDERICK GARDINER, M.D., B.Sc., F.R.C.S.E., F.R.S.E. Third edition. Edinburgh: E. & S. Livingstone, 1931. Pp. 283. 13 coloured plates. 46 illustrations. Price 10s. 6d.

We welcome this, the third edition, of Dr. Gardiner's well-known work, which has long been recognized as one of the best of the smaller text-books on dermatology. Only the commoner conditions are described, and the book is therefore eminently useful for purposes of revision before an examination.

We should like to draw attention to the excellent quality of the coloured plates and illustrations.

RECENT BOOKS AND PAPERS BY ST. BARTHOLOMEW'S MEN.

AINSWORTH-DAVIS, J. C., M.B., F.R.C.S. "Enlarged Prostate." *Proceedings of the Royal Society of Medicine*, February, 1932.

— "A Piece of Slippery Elm Removed from the Bladder." *Proceedings of the Royal Society of Medicine*, February, 1932.

ARMSTRONG, R. R., M.D., F.R.C.P. "Immediate Pneumococcal Typing." *British Medical Journal*, January 30th, 1932.

ATKINSON, E. MILES, M.B., F.R.C.S. "A New Tonsil Abscess Forceps." *Lancet*, April 16th, 1932.

BARNES, E. BROUGHTON, F.R.C.S.(Ed.). "Keloid of Mastoid Scar." *Proceedings of the Royal Society of Medicine*, February, 1932.

BOUCAUD, J. E. A., M.B. (and WATERMAN, J. A., M.B.). "Persistent Allantoic Diverticulum Causing Intestinal Obstruction." *Lancet*, March 12th, 1932.

COCHRANE, R. G., M.D., M.R.C.P., D.T.M.&H. "A Survey of the Modern Development of Leprosy Work (1917-1931); With an Appreciation of the Present Position." *British Journal of Dermatology and Syphilis*, March, 1932.

DUNDAS-GRANT, Sir JAMES, K.B.E., M.D., F.R.C.S. "Shortening an Elongated Uvula for the Cure of Cough." *British Medical Journal*, February 27th, 1932.

DUNHILL, T. P., C.M.G., M.D., Ch.B. "Horseshoe Kidney." *Proceedings of the Royal Society of Medicine*, February, 1932.

FLETCHER, ERNEST, M.B.(Camb.), M.R.C.P. "The Detection of Presymptomatic Tuberculosis in Children." *Lancet*, February 27th, 1932.

- HALDIN-DAVIS, H., M.D., F.R.C.P., F.R.C.S. "Some Recent Work on Psoriasis." *Practitioner*, February, 1932.
- "Some Interesting Drug Eruptions." *British Medical Journal*, March 5th, 1932.
- HARMER, DOUGLAS, M.A., M.B., M.Ch., F.R.C.S. "Two Cases of Carcinoma of Pyriform Fossa Treated by X-Rays." *Proceedings of the Royal Society of Medicine*, February, 1932.
- HEALD, C. B., C.B.E., M.D., M.R.C.P. "Paralysis Agitans." *Proceedings of the Royal Society of Medicine*, January, 1932.
- HOSFORD, JOHN P., M.S., F.R.C.S. "Some Factors in the Causation of Hydronephrosis." *Lancet*, February 27th, 1932.
- "Angioma of Epididymis." *Proceedings of the Royal Society of Medicine*, February, 1932.
- HOWELL, B. WHITCHURCH, F.R.C.S. "Sarcoma of the Foot." *Proceedings of the Royal Society of Medicine*, February, 1932.
- LYOYD, ERIC I., M.B., B.Ch., F.R.C.S. "Osteitis of the Tarsal Scaphoid (Bilateral); ? Cause." *Proceedings of the Royal Society of Medicine*, February, 1932.
- LYOYD, W. ERNEST, M.D., M.R.C.P. (DOROTHY J. DOW, M.A., M.B., Ch.B., and W. E. L.). "A Comparative Study of Chest Radiograms and the Mantoux Test in Children." *British Medical Journal*, April 16th, 1932.
- MACMAHON, CORTLANDT, M.A.(Oxon.). "A Note on the Treatment of Functional Aphonia." *Journal of Laryngology and Otology*, xlvii, No. 4, 1932.
- MCCURRICH, H. J., M.S. F.R.C.S. "Compressed Fracture of First Lumbar Vertebra; Reduction of Compression." *British Medical Journal*, May 5th, 1932.

ACKNOWLEDGMENTS.

Bulletins et Mémoires de la Société de Médecine de Paris—L'Écho Médical du Nord—Bulletin de l'Hôpital Saint Michel—Giornale della Reale Società Italiana d'Igiene—University of Toronto Medical Journal—McGill Medical Undergraduate Journal—Medical Times and Long Island Medical Journal—The Kenya and East African Medical Journal—Quarterly Journal of the Research Defence Society—The Leprosy Review—The Nursing Times—The British Journal of Nursing—The Hospital—The Birmingham Medical Review—Cambridge University Medical Society Magazine—Guy's Hospital Gazette—London Hospital Gazette—St. Mary's Hospital Gazette—Middlesex Hospital Journal.

EXAMINATIONS, ETC.

University of Cambridge.

First Examination for Medical and Surgical Degrees, December, 1931.

Part II.—Mechanics.—Frye, E.

Part III.—Physics.—Frye, E., Somerville, E. W.

Second Examination for Medical and Surgical Degrees, December, 1931.

Part I.—Organic Chemistry.—Edwards, T. A. W.

Part II.—Human Anatomy and Physiology.—Robins, J. M., White, D. M.

University of London.

Second Examination for Medical Degrees, March, 1932.

Part I.—Armstrong, J. H., Baker, F. J. S., Beeley, F. J. L., Bickford, B. J., Bradley-Watson, J. D., Brentnall, G. C., Cates, J. E., Clarke, E. P., Dancer, J. B., Dubash, J. J., Fairlie-Clarke, G. A., Fearnley, J. D. O., Flavell, M. P., Grundy, T. N., Harper, K. H., Henig, L., Hollands, F. G., Kinnear, A. I., Leask, L. R., Lewis, C. L., Lopez-Garcia, L. J., McGladdery, J. P., Moore, F. T., Ogilvie, J. D., Oliver, W. A., Roberts, J. L. D., Rotter, K. G., Samuel, D. M., Stoddart, W., Thackray, A. C., Vahrman, J., Williams, R. T. H.

Part II.—Anderson, C., Atkinson, E. C., Bangay, E. B. D., Barber, D. S. D., Barnard, E. J. W., Bohn, G. L., Cohen, S., Craig, D., Dransfield, C. M., Frost, L. D. B., Houghton, P. W., Hugh, H. M., Kennedy, A. R., McGladdery, H. M., Nash, D. F. E., Premdas, I. H., Rigby, E. P., Sansom, S. V., Tidswell, T. H., Weiner, B., Yarrow, H.

CHANGES OF ADDRESS.

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HARRISON, S. G., c/o Hon. D.M.S.S., Accra, Gold Coast, West Africa.

HOGGEN, G. HAMILTON, Council Offices, Swinton, Manchester.

RADCLIFFE, W., The Grove, Dedham, Essex.

SODEN, W. N., Queen Mary's Hospital, Roehampton, S.W. 15.

TOOTH, R. S., The Gables, Southover, Lewes.

APPOINTMENTS.

- BURROWS, H. J., M.B., B.Chir.(Cantab.), F.R.C.S., appointed Honorary Cytologist, Royal College of Surgeons; appointed Honorary Orthopaedic Surgeon, East Ham Memorial Hospital.
- HECKFORD, F., M.R.C.S., L.R.C.P., appointed Honorary Ophthalmic Surgeon to the Royal Isle of Wight County Hospital.
- LLOYD, W. ERNEST, M.D., M.R.C.P., appointed Assistant Physician to the Brompton Chest Hospital.

BIRTHS.

- BONNER-MORGAN.—On April 4th, 1932, at Penang, to Susan, wife of W. R. Bonner-Morgan—a son.
- DIETRICH.—On February 29th, 1932, to Thelma (née Corder) wife of Gilbert Dietrich, M.R.C.S., L.R.C.P., of Northmead, Benoni, S. Africa—a son.
- DRURY.—On March 20th, 1932, at Maseno, Kenya, to Helen Flora Hewlins (née Catling), wife of Dr. Graham Dru Drury—a son.
- HORDER.—On April 16th, 1932, at Ben-lui, Boyne Park, Tunbridge Wells, to Jessie, wife of Cecil A. Horder, M.B., F.R.C.S.—a son.
- MUIR.—On April 21st, 1932, to Eleanor (née Stirling) and David Miller Muir, of Exeter—a son.
- SALMON.—On April 1st, 1932, at Wolverhampton, to Muriel, wife of K. Gordon Salmon, M.A., M.B., B.Ch.—a daughter.

MARRIAGES.

- BOLTON—WILSON.—On March 31st, 1932, at the Wesleyan Church, Donaghadee, by the Rev. Chas. Wilson (father of the bride), assisted by the Rev. H. B. Rattenbury, Ralph, youngest son of Mr. and Mrs. Edward Bolton, Charlbury, Oxfordshire, to Eileen Margaret, eldest daughter of Rev. and Mrs. Chas. Wilson, Donaghadee, Co. Down.
- HAMILL—FINDLATER.—On April 7th, 1932, at Our Lady of Victories, Kensington, by the Rev. W. Owen, D.D., John Molyneux Hamill, O.B.E., M.D., D.Sc., to Lesley, daughter of the late R. B. N. Findlater and Mrs. Findlater, of 187, Queen's gate, S.W. 7.
- RIDSILL SMITH—LATHAM.—On April 7th, 1932, at the Church of the Holy Cross, Morton, Thomas Ridsill Smith, son of the late Mr. T. Ridsill Smith and Mrs. R. G. D. Laffan, to Dorothea Mary, daughter of the Rev. W. L. and Mrs. Latham, Morton Rectory, Derbyshire.

DEATHS.

- EVANS.—On March 15th, 1932, at Felinfach, Cardiganshire, Evan Evans, M.R.C.S., L.S.A., D.P.H.
- GOODWIN.—On April 1st, 1932, at the Old School House, Catcott, Bridgewater, Wycliffe Goodwin, M.B., late of Rhyl, North Wales, aged 65.
- IZARD.—On February 16th, 1932, suddenly, at Auckland, New Zealand, Dr. Arnold Woodford Izard, O.B.E.
- ORCHARD.—On March 23rd, 1932, at 12A, Kensington Court Place, Timothy, the infant son of Dr. and Mrs. Stuart Orchard, aged two days.
- SMITH.—On March 31st, 1932, James Edmund Smith, M.R.C.S., L.R.C.P., of 44, Whiteheads Grove, Chelsea, S.W.
- STEPHEN.—On April 11th, 1932, suddenly, at Bordighera, Lieut.-Colonel Guy Neville Stephen, O.B.E., M.R.C.S.(Eng.), D.P.H. (Lond.), Officier de Santé France, late Foreign Office Medical Service and R.A.M.C., third son of His Honour the late Judge James Stephen, aged 74.

NOTICE.

All Communications, Articles, Letters, Notices, or Books for review should be forwarded, accompanied by the name of the sender, to the Editor, ST. BARTHOLOMEW'S HOSPITAL JOURNAL, St. Bartholomew's Hospital, E.C. 1.

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